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COMMITTEE PRINT

HEALTH CARE PROBLEMS OF THE BLACK ELDERLY

A BRIEFING

BY THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

JUNE 24, 1989, COLUMBUS, OHIO

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HEALTH CARE PROBLEMS OF THE BLACK ELDERLY

SATURDAY, JUNE 24, 1989

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice at 9:05 a.m. in Delaware Room C, Hyatt Regency Hotel, 350 N. High Street, Columbus, Ohio, Hon. Mary Rose Oakar (acting chairwoman of the committee) presiding.

Members present: Representative Oakar.

Staff present: Diana Jones, Staff Assistant, Select Committee on Aging.

OPENING STATEMENT OF CHAIRWOMAN MARY ROSE OAKAR

Ms. OAKAR. The Select Committee on Aging will come to order. My name is Mary Rose Oakar, I am a Member of Congress from Cleveland, Ohio, and lucky enough to represent Cleveland along with my good friend Congressman Lewis Stokes, who I understand addressed the National Caucus and Center on Black Aged Convention last night. I was delighted that Congressman Stokes was going to have that honor and privilege, and you certainly could not have heard from a more outstanding Member.

I would like to say that the Select Committee on Aging is especially interested in the whole question of health care and how it affects our Black elderly. This is the second hearing that has been conducted by the Select Committee on Aging. Our Chairman, Congressman Ed Roybal, who is from Los Angeles, California, himself is a minority. He is a member of the Hispanic Caucus and very concerned about issues that relate to members of the minority, particularly minority elderly, and he regrets that he cannot be here himself. Congressman Roybal, I know, would want me to welcome all of you here at this hearing.

I am delighted to have Diana Jones, who is a member of our staff of the Select Committee on Aging, they do most of the work and provide us with much of the information.

I wanted to tell you a little bit about myself, mainly because I want all of you to know one of the things we are trying to do as a Congress, and something that has been mandated by law. Senator Claude Pepper, who as you know, several weeks ago passed away, had a dream—along with Congressman Roybal—of having long-term care and comprehensive health care for all Americans. As you know, we have 40 million Americans in this country of ours

who have absolutely no access to health care, and we certainly do not have a long-term care program for our older Americans, let alone our disabled or children who are disabled or have those kinds of needs.

And under the catastrophic bill that is somewhat controversial we understand—but under that bill mandated by law, we set up a commission to study the issue of long-term care and comprehensive health care. Claude Pepper had a dream of having health care for every American and he worked on that for 40 years, and in his own ill health when he was dying, he communicated to me and others that his most ardent wish was the needs—health needs of others, he was talking about the health needs of others, not of himself. And so we have a commitment to do something about it.

I serve on that commission. In fact, I was just saying that out of 15 commissioners I am the only woman on the commission, and there are no minorities on the commission. These are commissioners appointed by the President, by the Speaker of the House and the minority leadership of the House and the committee in the Senate. And we feel strongly that someone from a minority background, Hispanic, Black, et cetera, ought to be—I really feel strongly that they ought to be on the commission. So you never know, the Speaker has another appointment now with the death of our dear friend who is going to be watching over us making sure that we do something about access to health care for every American.

So I mention that—on July 6 in my hometown, which is Cleveland, Ohio just north of here, at 9:30 in the morning, we are going to have a hearing bringing our commissioners into Cleveland to have a national hearing on the subject of comprehensive health care and long-term care for every American. And we are hoping that any of you who wish to participate in that hearing or testify, if you would just call my office or let me know before I have to leave today, I would be delighted to have your testimony or you personally testify. We think it is very, very important.

The commission has 6 months in which to write a report for Members of Congress and the President, and this is a commission that is a very active commission. Senator Kennedy is on it, Senator Heinz, Mr. Waxman who has done a lot of good work in health care and so on—I do not mean to demean the commission because it is composed primarily of white males, but I do mean to say that I think that there needs to be a little more cross-section of Americans on that commission. And we are going to try our best to do a good job.

Well this is—I am just going to submit for the record some facts that I have relative to the needs of our Black elderly, demographics and income.

[See Appendix 1, p. 83 for material submitted by Ms. Oakar.]

The Census Bureau projects that there are approximately 2.5 million Blacks 65 years or older, approximately 60 percent are women. And something that is interesting to me, I have done a lot of work in the area of Social Security and 95 out of 100 Americans are covered by Social Security or have access to it. The 5 percent who are not covered are usually elderly Black women. They were the ones, like Congressman Stokes' own mother, who were the domestics, you know, and they had no access to any kind of insur-

ance, whether it was insurance for one's retirement or health insurance. And so I think that contributes to the whole anguish of poverty among Black American women in particular.

The number of Black elderly is expected to increase at least twice as fast as the number of white elderly. I do not have to tell you that the fastest growing population in this country are people over 85, and yet the life expectancy for Black males at birth is approximately 65 years and the life expectancy for Black women is approximately 74 years. And so we know that, for example, the death rate from lung cancer is 45 percent higher for Black males compared to white males, and we know that certain other types of cancers and hypertension is a much more serious problem for Blacks than whites, et cetera.

I am going to submit for the record all of these statistics and some facts that we have gathered, but I am really here to learn and I am delighted to have such a distinguished panel, I really am.

Before we hear from our first witness, I would like to submit for the hearing record the prepared statement of the Chairman of this committee, along with the prepared statement of another Member of Congress who was unable to attend today's proceedings.

[The prepared statements of Representatives Roybal and Stokes follows:]

OPENING STATEMENT

EDWARD R. ROYBAL
CHAIRMAN
SELECT COMMITTEE ON AGING

"HEALTH CARE PROBLEMS OF THE BLACK ELDERLY"

Saturday, June 24, 1989

Good morning. I would like to begin by expressing the thanks of the Select Committee on Aging for inviting the Committee to this annual meeting of the National Center/Caucus on the Black Aged. I would also like to congratulate them on another successful year of their efforts on behalf of the older African American community which they so ably represent in Congress and nationwide.

Today we are convening a hearing on the current health status of older blacks in our nation.

We so often say in many discussions about the elderly that they are a heterogeneous population of individuals. It is all too often the mistake that people will overgeneralize about the conditions of the elderly. The only valid generalizations that can be made about the aged in this country is that they have lived more years in their lives compared to the general population and that they have a little more wisdom because of those life experiences.

The same can be said about the black elderly. While the population is generally descendent of the African peoples, the African American community has varied characteristics also. It is difficult to pinpoint what had been formally referred to as "nonstandard black english." Blacks from Watts in Los Angeles

use different slang than those living in the Mississippi Delta area. A year ago, the Aging Committee held a hearing that received testimony from Unita Blackwell, the Mayor of Mayersville, Mississippi, in which she discussed the difficulties that she encountered in trying to develop adequate housing for her elderly residents in a rural setting. The plight of the urban poor has specific problems that are not necessarily encountered by those living in rural communities. The essence of my argument is that we as policy makers must remain sensitive to the needs of a varied population and must guard against overgeneralization of any one subpopulation of Americans. Unfortunately, due to the lack of quality data about many of the elderly populations, this tendency exists and must be fought against. Especially when dealing with statistical data on older populations.

In the area of health, it is very difficult to obtain reliable, specific data dealing with health issues affecting older blacks. There exists a need to depend on somewhat generalized data. Studies indicate that the health status of older blacks is poor compared to their white counterparts. Black elders have higher rates of chronic disease, functional impairment and indicators of disease, such as high blood pressure. Mortality rates for the aged black are high than those for older whites. Yet some studies have indicated that after the age of seventy-five years, older black's mortality rates improve while chronic health conditions worsen. Statistics show that older black individuals are bed-ridden more often and

report poorer health conditions than older whites. Heart disease, stroke and cancer are among the diseases that affect the older black disproportionately compared to the older white population.

We need to remember when developing policy that there is a strong correlation between income and health. Often due to an individual's income, he or she may not be able to afford proper health care, or insurance to cover the high costs of health care. The individual may not even be aware of health care programs such as Medicare and Medicaid that are available. Keeping our population healthy for a longer, higher quality life is but one of the goals in an overall aging policy for this nation. One way to implement this would be to work towards providing universal health insurance for all Americans. That would be the ideal method for attacking the problem of the over 30 million uninsured citizens of this nation. By ensuring that the elders are able to live longer, more productive, healthy lives, we can begin to grapple with the other social-economic issues facing all Americans, especially the older populations in need.

Thank you.

STATEMENT

OF THE

HONORABLE LOUIS STOKES

(D-OH)

BEFORE THE

SELECT COMMITTEE ON AGING HEARING

ON

HEALTH CARE PROBLEMS OF THE BLACK ELDERLY

CLEVELAND, OHIO

JUNE 24, 1989

MR. CHAIRMAN. Thank you for this opportunity to make a statement before the Select Committee on Aging. I am aware that this hearing was scheduled to coincide with the National Caucus and Center on Black Aged (NCBA) Annual Conference. While I am unable to appear personally before the Committee on this occasion, I did have the honor of speaking last night at the NCBA Annual Community Awards Banquet. In this regard, I am submitting my remarks from last night to the Committee. I also am pleased to have this time to make a statement on an issue that I know is of great concern to all of our senior citizens, and in particular to our Black aged; that issue is health care.

First, let me commend you and Congresswoman Oakar for taking the initiative to hold this important hearing. I am equally pleased that this forum is taking place in my home of Cleveland. During my tenure in Congress, some of my most vocal and active constituents have been the elderly. And of all the concerns that they have time and time again expressed, none has been as overwhelming a concern as that of health care.

Your examination of this issue is especially critical at a time when our nation is trying to develop strategies to provide quality and comprehensive health care to all Americans, especially the poor, elderly and uninsured. Furthermore, I am sure you are aware that, of all segments of our society, minority Americans possess some of the greatest health needs of all groups -- from infancy to old age.

As a member of the Labor-Health and Human Services-Education Appropriations Subcommittee, and as Chairman of the Congressional Black Caucus Health Braintrust, I have represented the health and welfare concerns of Black and other minority Americans, and have advocated for improved health care for these needy and underserved populations. I believe that one of the groups most in need of better and increased health care services is our Black aged.

Mr. Chairman, during the past several years, the quality of life for many of our Black senior citizens has been jeopardized by such things as escalating health care costs, unaffordable housing and increasing impoverishment. They have worked hard to support our nation and our community, and should not have to worry about enjoying their twilight years. Most importantly, they should not be burdened with such basic problems as health care -- which in my opinion should be a guaranteed right.

Again, let me commend you for addressing this important and continuing concern confronting our elderly. I look forward to the outcome of your committee's deliberations, and pledge my support in your efforts to come up with viable solutions to meet this need.

Ms. OAKAR. So what we are going to do is have the panel give their testimony. If you want to give the entire testimony, fine, but if you want to summarize, we can have more of a discussion, so that we can get into some of the questions that I would like to see answered.

Our first witness is Dr. Suzanne Randolph, who is the Assistant Professor at a very fine institution, the University of Maryland. She is in the Department of Family and Community Development. Next, we have Dr. Barbara Jones Morrison, who is Associate Commissioner for Long-Term Care from the State of New York Mental Health Office in Albany. Then we have Ms. Cheryl Boyce, who is the Executive Director of the Ohio Commission on Minority Health—I am proud of my State for having a Department of Minority Health—in Columbus. The Governor should be congratulated. He gets rapped all the time, you know, but he has done some very fine things, I think. And we have Mr. Roland Hornbostel, who is with the State Long-Term Care Ombudsman for the Ohio Department of Aging, another fine innovation by our State. We are delighted to have you. And Ms. Larke U. Recchie, who is the Director of the Central Ohio Area Agency on Aging, here in Columbus.

So thank you very much, this will be very helpful to us. Dr. Randolph, if you would like to begin, we are delighted to have you here.

STATEMENT OF SUZANNE M. RANDOLPH, PH.D., ASSISTANT PROFESSOR, DEPARTMENT OF FAMILY AND COMMUNITY DEVELOPMENT, COLLEGE OF HUMAN ECOLOGY, UNIVERSITY OF MARYLAND, COLLEGE PARK, MARYLAND

Dr. RANDOLPH. Thank you. I am pleased to be here also. Good morning.

Ms. OAKAR. Good morning.

Dr. RANDOLPH. I am, as I said, pleased to have this opportunity to be here. I'm Suzanne Randolph, I am a developmental psychologist and as Congressman Oakar said, I am a professor at the University of Maryland. My testimony though is based on my involvement during 1986 and 1987 as a coinvestigator, a research director, along with Carole Kauffman at the American National Red Cross. The study was funded in part by the Administration on Aging and it was conducted in collaboration with the Congress of National Black Churches. My remarks do not reflect the views of any of these organizations or the University of Maryland, but rather they are based on my conclusions as an independent investigator who continues to have interest in this area.

The study as it was funded was entitled "The Characteristics and Needs of Black Caregivers and their Elderly Clients in Personal Care Homes". I have submitted an Executive Summary for the record. The short title, or what we like to refer to the study as is "The Black Elderly Caregivers Study".

We conducted face-to-face interviews with some 152 caregivers and 184 of their Black elderly clients in what we refer to as personal care homes. These are community based homes in which the elderly are being cared for on a full time basis in a private residence by the owner of the home or in a dwelling owned by the elderly.

The distinction that we made, however, is that different from other research studies is that the caregivers were nonfamily members of the elderly.

The personal care homes may be the only option available for the Black elderly in some geographical areas when traditional family networks change, such as when younger members migrate out of rural communities and when family networks break down or do not exist.

Our study was intended to provide information that would guide program development, future research and the formulation of policy options to assist such caregivers and care receivers, the Black elderly that is, in these homes. We conducted interviews in five urban sites; Atlanta, Baltimore, Cleveland, Detroit and Oakland, and in four rural sites in Alabama, Mississippi, North Carolina and South Carolina.

We found that (1) the characteristics of the Black elderly demonstrated that their demands for care could be considerable, their median age was 76 years, most were females living below the poverty level and many reported one or more health problems, including diabetes, high blood pressure, arthritis, cancer, angina and anemia.

Secondly, the profile of the caregivers was mixed. Some of them too were at risk themselves because of age, health and poverty. Their median age was 55 years, most were Black females and again living below the poverty level.

Thirdly, both caregivers and their elderly clients reported a wide range of activities and services provided by caregivers though—and this was our fourth finding—caregivers got very little assistance from relatives, formal agencies or others in providing such services, and lastly, most caregivers reported that they had received some training related to caregiving, but wanted more training.

Some of the tasks necessary to address these needs can be easily accomplished by community organizations but others will require your attention as policymakers. The following are the eight policy options we recommended:

We urge your support of (1) funding for continued training, education and on-site demonstration for caregivers in personal care homes. The availability of such training should increase the quality of care available to the Black elderly and furthermore, by increasing the skills, ability and self-reliance of caregivers, it may also increase their levels of life satisfaction.

(2) Funding for programs that provide case managers and nursing consultation for caregivers and care receivers in personal care homes. As both the Black elderly and their caregivers get older, their demands and needs for care will increase. Thus, expert nursing consultation for the Black elderly, development of care plans and 24-hour consultation would benefit both caregivers and care receivers.

(3) Legislation that expands the home care benefits available under Medicare to include nonmedically based services for nonhomebound individuals with chronic conditions. There was a need among the Black elderly in this study for home health care and services rendered outside of institutions. There was also need indicated for services that offer support and assistance to the caregiver

such as adult day care. The availability of the funding would strengthen the ability of the elderly to remain self-sufficient and possibly prevent premature institutionalization.

(4) Intensify social and health service planning, particularly in the southeastern States and other rural areas, and needs clarification to suppliers of transportation and other services. Many more caregivers and care receivers would be able to take advantage of medical care facilities, social activities and other opportunities if transportation for the frail or handicapped elderly is more readily available.

(5) Provide respite care services for caregivers of the elderly. The majority of caregivers indicated that they sometimes feel a need to escape from the caregiving site. Available quality respite care will provide opportunities for the caregivers to escape to attend to personal needs and to attend training sessions to upgrade their skills. Respite care also provides care receivers with care, companionship and stimulation from a committed individual other than the regular primary caregiver.

(6) Increase efforts to disseminate information about the needs of older Black women, using media, especially TV campaigns and public service announcements. This approach may encourage the elderly and their caregivers to seek out information on aging services. The research data from this study indicated that the majority of personal care home caregivers and care receivers is composed of Black females living below the poverty level. The data also indicated some lack of knowledge on their part about Federal and local programs for the elderly.

(7) Provide funding for research comparing various elderly populations to explore problems that keep Black and other elderly from participating fully in programs for the elderly. There is a void in the current literature about caregiving arrangements for the Black elderly outside of the immediate family and institutional settings. Through research, more information would be available in developing policies and programs to serve various elderly groups more adequately.

And finally (8) Funding to support greater research emphasis on the attitudes of various groups, especially Black, poor, and rural elderly regarding alternative housing and health care arrangements. There is currently a dearth of literature on the attitudes of the elderly toward specific health care arrangements and housing options. This research data may guide future policy and planning regarding use of services and programs.

In conclusion, the response to the needs of the Black elderly, as identified in this study, will require the public, private and nonprofit sectors of this country to work together to improve the quality of life for the most senior members of society. In particular, support is needed for Black aging women. Without this support, the current notion of quadruple jeopardy—that is, being Black, poor, old and female—will quickly give way to a new notion, quintuple jeopardy—being Black, poor, old, female and a caregiver—a notion which will threaten the personal care home as an optional health care arrangement for the Black elderly. This study was but one small effort toward making such support possible.

Thank you for the opportunity to share its findings and recommendations with you.

[The prepared statement of Dr. Randolph follows:]

TESTIMONY

ON

HEALTH CARE PROBLEMS OF THE BLACK ELDERLY

BEFORE THE

HOUSE SELECT COMMITTEE ON AGING

U. S. HOUSE OF REPRESENTATIVES

ON JUNE 24, 1989

PRESENTED BY

SUZANNE M. RANDOLPH, PH.D.

ASSISTANT PROFESSOR

DEPARTMENT OF FAMILY AND COMMUNITY DEVELOPMENT

COLLEGE OF HUMAN ECOLOGY

UNIVERSITY OF MARYLAND

COLLEGE PARK, MARYLAND

Good Morning. My name is Suzanne Randolph. I am a developmental psychologist with research interests in health-related issues affecting developmental outcomes for African Americans across the life span. I am currently an Assistant Professor of the Department of Family and Community Development at the University of Maryland at College Park. My testimony is based on my involvement as a co-investigator, along with Carole Kauffman, R.N., M.P.H., in a research study funded by the U.S., Department of Health and Human Services, Office of Human Development Services, Administration on Aging (AoA). The study was conducted under a grant from the AoA to the American National Red Cross, in collaboration with the Congress of National Black Churches, during 1986 to 1987. My remarks do not reflect the views of any of these organizations, but rather conclusions drawn as an independent investigator who continues to have interest in this area.

The study to which I will refer is known popularly as the Black Elderly Caregivers Study. Its full title, as funded, was "The Characteristics and Needs of Black Caregivers and Their Elderly Clients in Personal Care Homes." An Executive Summary is submitted for the record which describes the study in some detail, highlights the major findings and presents the recommendations based on these findings. I will use the findings from the study to frame my testimony.

Briefly, the study was designed to identify the needs and characteristics of caregivers and their black elderly clients in community-based personal care homes. Personal care homes are defined as those community-based arrangements in which the elderly are being cared for in a private residence by the owner of the home or in a dwelling owned by the elderly on a full time basis, and in which no more than six such persons are receiving care. The study was intended to provide information that would assist non-profit organizations, churches, community groups, and government agencies in identifying ways to strengthen the caregivers' support of the black elderly in these personal care arrangements and to provide insights into future research.

The significance of this study lies in its emphasis on community-based long-term care needs of the black elderly since little research has focused on such issues, beyond studies of family members as caregivers and of nursing home populations. Examination of the needs of the black elderly is particularly important in view of the projected rapid growth of this population (a projected increase of 45.6 percent between 1980 and 2000) and because of the overall poverty rate (32 percent for black elderly and 57 percent for older black women living alone). Furthermore, personal care homes may be the only option currently available for the black elderly in some geographical areas when traditional family networks change, such as when younger family members migrate out of rural communities leaving little or no family networks behind, and when family networks breakdown or do not exist. The rising divorce rates among black families suggest that this pattern, too, may affect the availability of family caregivers, particularly for women.

We were able to conduct face-to-face interviews with caregivers and the black elderly in five urban sites (Atlanta, GA; Baltimore, MD; Cleveland, OH; Detroit, MI; and Oakland, CA); and four rural sites (counties in Alabama, Mississippi, North Carolina and South Carolina). A total of 153 caregivers and 184 carereceivers (the black elderly clients) were interviewed. Most of the personal care homes (62%) were in rural communities. The following is a summary of our major findings.

ELDERLY'S Characteristics and Needs

Ages ranged from 49 to 104; the median was 76 years.

Those over 75 years comprised 57 percent of sample.

Only 15% were married; most were widowed (55%).

Most had less than a high school education (66%).

Most were reported monthly incomes below the poverty level.

Social Security was the most frequently reported source of income (60%), followed by SSI (32.5%) or pension (48%); one third had no income.

Data suggest some were eligible for, but not receiving SSI; outreach and information about SSI and help in enrolling in this program may ensure that those who are eligible can receive benefits.

HEALTH

They viewed themselves as a particularly frail group (38% reported health at time of interview as poor, 32% fair);

Most (56%) reported health as better or the same since they had come to the home.

Caregivers were more likely to report their clients' health as fair or good.

The most frequently reported illnesses or health conditions were diabetes (42%), high blood pressure (33%), arthritis and angina (each 30%), cancer (29%), and anemia (27%).

About 87% were on one or more prescribed medications.

A third required special diets/foods under physician's orders.

Most have a regular source of medical care.

Equipment and assistive devices used included: vision aids (69%), dentures (52%), walkers (39%), canes (34%), bedside commodes (26%), and wheelchairs (24%).

UNMET NEEDS

Activities of Daily Living (ADL):	Instrumental ADL (IADL):
Bathing (26%)	Housework (31%)
Bed/chair transfer (16%)	Meal preparation (27%)
Dressing (13%)	Transportation (26%)
Eating (4%)	Grocery shopping (23%)
Toileting (3%)	Telephone use (20%)
	Money management (9%)

CAREGIVERS' Characteristics and Needs

The portrait of the caregivers in this study sample suggests that they, too, are a vulnerable group.

Many report incomes below the poverty level (70%), with their only source of income from caregiving (70%).

Over 60% were single and nearly one half of those were widowed.

Ages ranged from 15 to 87, with a median of 55 years.

Their education varied widely with the majority having completed high school or better (52%).

Almost all were women.

HEALTH

Over a fourth (29%) reported their health as fair or poor, while the rest reported it as good (49%) or excellent (22%).

Fewer health conditions and illnesses were reported by caregivers than their clients reported, but for those who did the most frequently reported were high blood pressure (46%), arthritis (44%), or anemia (18%).

About 20% had been admitted to a hospital in the previous year.

About 10% report sick days in bed.

A third were under doctor's orders for special diets/foods.

Their general sense of well-being was positive.

SERVICES PROVIDED

The full range of ADL and IADL were provided, with over half reporting they had been giving care to older people for more than five years. Payments for services came from social service agencies (47%), medicaid/medicare (25%), the elderly clients (23%), health insurance (6%) , and the elderly's families (9%).

Most say they do not need help with IADL or ADL: transportation (19%), housework, meal preparation; 21% need help with ADL.

They get some time off, but over half do not have a regular schedule away from caregiving, though the majority felt the need to escape sometimes or often.

About 24 percent gave medical treatments in the home, including oral medications, injections, oxygen, changing bandages, and I.V. medications.

Many have received some training related to caring for someone at home (first aid, vital signs, home nursing, and CPR--all 50% or over). Nearly two-thirds had no

courses on aging and elderly care, stress management, or money management; many (62%) would like additional training in care of elderly, home nursing, first aid and CPR.

SUPPORT SERVICES

Few reported receiving help from their family or their clients', other relatives, or agencies; nearly half perceive a need for more help with IADL.

Services provided by others that were found to be most useful were in order of frequency: health and social services provided by local agencies, help in and around home, in-service training, transportation and financial support.

Respite services are needed that would permit caregivers time off from caregiving to widen their own social experience and to participate in training and to provide additional social experience for elderly clients.

SUMMARY AND POLICY RECOMMENDATIONS

As the age of the carereceiver increases, one can anticipate that their demands for care will also increase, and if their health deteriorates, increasing demands for more complex care are likely. Yet, their caregivers, just as family caregivers, are also approaching or are in the older age groups.

While personal care home living arrangements may be suitable in the short term the increasing needs of both the caregivers and carerecivers will require additional assistance and support from outside agencies. In addition, because of the multiple needs of many carereceivers and caregivers, case management by nursing and social services should strongly be considered for this population.

Some tasks are easily accomplished by community organizations, but others will require your attention as policy makers:

1. Provide funding for continued training, education, and on-site demonstration for caregivers in personal care homes.

The availability of training increases the quality of care available to the black elderly. Furthermore, increasing the skills, ability, and self-reliance of caregivers may increase their levels of life satisfaction.

2. Support funding of programs that provide case managers and nursing consultation for caregivers and carereceivers in personal care homes.

Both caregivers and their black elderly clients found services from the formal health and social service systems to be the most helpful of the available resources. As the black elderly get older (median age in study was 76 years), their demands and needs for care will increase. Meanwhile, the age of the caregivers will also be increasing (median age was 55 years in this study), affecting caregiver needs, especially assistance with their own health. Expert nursing consultation for the black elderly, development of care plans, and 24-hour consultation would benefit both caregivers and carereceivers.

3. Support legislation that expands the home care benefits available under Medicare to include non-medically based services for non-homebound individuals with chronic conditions.

There was a need among the black elderly in this study for home health care and services rendered outside of institutions. There was also need indicated for services that offer support and assistance to the caregiver such as adult day care. The availability of the funding would strengthen the ability of the elderly to remain self-sufficient and possibly prevent premature institutionalization.

4. Support and intensify social and health service planning, particularly in the southeastern states and other rural areas, and provide needs clarification to suppliers of transportation and other services.

The respondents in this study indicated a need for assistance in transportation and related services. Many more caregivers and carereceivers would be able to take advantage of available resources (medical care facilities, social activities and other opportunities) if transportation for the frail or handicapped elderly is readily available.

5. Support respite care services for caregivers of the elderly.

The majority of caregivers indicated that they sometimes feel a need to escape from the caregiving site. In addition the caregivers need to be able to leave home for shopping, banking and other duties for themselves and the carereceivers. Available quality respite care will provide that opportunity for the caregivers to leave home knowing that the carereceiver is well cared for. In addition, caregivers will be able to attend training sessions to upgrade their skills. Respite care provides carereceivers with care, companionship, and stimulation from a committed individual other than the regular primary caregiver.

6. Increase efforts to disseminate information about the needs of older black women, using media, especially TV campaigns and public service announcements.

This approach may encourage the elderly and their caregivers to seek out information on aging services. The research data from this study indicated that the majority of personal care home caregivers and carereceivers is composed of black females living below the poverty level. The data also indicated some lack of knowledge about federal and local programs for the elderly.

7. Provide funding for research comparing various elderly populations (male/female, minority/majority, urban/rural, etc.) to explore problems that keep black and other elderly from participating fully in programs for the elderly.

There is a void in the current literature about caregiving arrangements for the black elderly outside of immediate family and institutional settings. Through research more information would be available for use in developing policies and programs to serve various elderly groups more adequately.

8. Provide funding to support greater research emphasis on the attitudes of various groups, especially black, poor, and rural elderly regarding alternative housing and health care arrangements.

There is currently a dearth of literature on the attitudes of elderly toward specific health care arrangements and housing options. Research data may guide future policy and planning regarding use of services and programs.

In conclusion, the response to the needs of the black elderly as identified in this study will require the public, private and non-profit sectors of this country to work together to improve the quality of life for the most senior members of society. In particular, support is needed for black aging women. Without this support the current notion of "quadruple jeopardy" (that is, being black, poor, old and female) will quickly give way to a new notion, "quintuple jeopardy" (being black, poor, old, female and a caregiver),-- a notion which will threaten the personal care home as an optional health care arrangement for the black elderly. This study was but one small effort toward making such support possible. Thank you for the opportunity to share its findings and recommendations with you.

Ms. OAKAR. Dr. Randolph, thank you very much for your very concise statement. Let me just say to any of our witnesses and to members of the audience that might have something that they would like to put in for our record, we think it is very important to have a record that is complete, so if any of you have statements that you would like to send in to the committee, I am sure Diana will tell you how to do that. We will keep this record open so that we can get as much information as possible and do something about this terrible problem.

So thank you very much, Dr. Randolph. I am going to hold my questions for all of you, because I think we are going to move along and then I have some questions for you as a panel.

Dr. Barbara Jones Morrison, we are delighted to have you, Associate Commissioner for Long-Term Care from New York State. That is an issue that we are really working on, so—we are trying anyway—so we are happy to have your testimony.

STATEMENT OF DR. BARBARA JONES MORRISON, ASSOCIATE COMMISSIONER OF LONG-TERM CARE, NEW YORK STATE OFFICE OF MENTAL HEALTH, REPRESENTING THE NATIONAL CAUCUS AND CENTER ON THE BLACK AGED, INC.

Dr. MORRISON. Thank you, it is a pleasure to be here and I would like to extend my appreciation to the Select Committee on Aging for inviting me, and also the National Caucus and Center on Black Aged.

For the sake of brevity, I am going to pass over much of the statistical material which appears in my written comments and just summarize briefly to note that in my paper I do examine a number of physical health problems prevalent among the Black elderly as a basis for documenting the need for long-term care services, some of which were mentioned by you, Chairwoman Oakar, in your initial remarks.

Let me pass over some of those and just echo the sentiments that Dr. Randolph made about issues related to poverty and poor health. I would like to say a few words about use of long-term care services by the Black elderly and then also make some preliminary recommendations.

In spite of their higher disease and disability levels, older Blacks have historically underutilized long-term health care services such as skilled nursing homes, health related facilities and home care services. Reasons for this underutilization have been attributed to several factors: cultural preferences for family based, as opposed to institutional care of frail elderly, racial and class bias in both referral and admission to long-term care facilities, lack of long-term care services development in areas where Black persons reside, lack of culturally relevant service design, the high cost and low insurance coverage for long-term care and lack of sophistication on the part of Black elderly and their families in gaining access to limited nursing home beds.

It is particularly important that the frequently cited preference of Black families to care for their own be validated as options for care are explored and assessed. Even if this is a family preference, the ability to act on it will depend on competing demands for the

family's financial, physical and emotional resources. Black families must be helped to understand the advantages and disadvantages of different care options while being helped through advocacy and case management to access needed services.

One of the critical areas that I am concerned about relates to manpower shortages in long-term care. The involvement of minority persons as health and mental health care professionals and managers is key to the adequate provision of health services to Blacks of all ages. Minority enrollment in medical schools and other professional schools such as nursing and social work has been declining in recent years. Such a trend is very disturbing. The long-term care needs of the elderly in general and the Black elderly in particular will not be adequately addressed until sufficient attention is paid to the severe manpower shortages in service areas such as home care and residential health care. When such resources are scarce, it is the poor and minority elderly who are least likely to compete successfully for such resources.

In terms of recommended strategies, let me first note that what I am going to suggest is not new or innovative. These recommendations have come up over and over again in the past 20 years in the health care literature. Many of them in fact are recognized and addressed in the Elderly Mental Health and Services Development Reform Act of 1988 sponsored by Chairman Roybal. The reason that they need repeating is because progress toward meeting these strategies has been incredibly slow.

I think it is one of the supreme ironies that when you work in the field of long-term care, you become more and more an advocate for prevention and health care promotion. One of the things that is very clear is that a lot of the disease and disability which is suffered by older Blacks is the result of a lifetime of poor health care, poor nutrition, all of the things that I am sure we will address later in our remarks. What I suggest is that there needs to be a very concerted effort toward better health care and health promotion. This is one area in which we as policymakers pay an awful lot of lip service, but devote very few resources to the provision of health prevention services.

I would like to advocate for increased Federal and State funding to local governments and organizations to organize health fairs where health screening and health education activities can be offered, including such services as risk disease screening, health education and referral to services for at-risk individuals. I would like to advocate for increased Federal assistance to local health organizations to develop health screening teams which can go to individual or group settings where at-risk Black elderly are likely to be found. Through early detection and quick referral to appropriate health and mental health agencies, more Black elderly might be spared unnecessary illness and disability.

I would note one strategy that we used in New York. Very often when we had health activities, we found that a lot of women turned out and the men did not. So we took our health screening to barbershops on Saturday morning, and we were able to pick up a lot of Black older men through this approach.

Improve the resources among older Blacks to promote health, encourage State and local agencies to do more to provide information

on entitlement programs which would enhance the income and health resources of older Blacks. I think one particular trend which I find very disturbing is that, at least in New York State, there has been a documented decrease in participation in older American programs by minority elderly. We are very concerned about this trend, and as a State are looking at ways to increase participation.

Increase Medicare coverage for long-term care services. Current Medicare coverage for home health care and nursing facility care is very limited and focused on post-acute convalescent care. Longer term health services, where they exist, are funded largely by Medicaid at considerable cost to States.

Promote development of private, long-term care insurance. Although many Black elderly rely solely on public health insurance mechanisms such as Medicare and Medicaid, there is a growing private insurance industry in long-term care. Black consumers should not be overlooked as a potential market for these products, especially if offered as part of a menu of work-related benefits.

New York at the moment is part of a multi-State project funded by the Robert Wood Johnson Foundation to study aspects of marketing long-term care insurance such as actuarial projections and coverage patterns, and I think special attention needs to be paid to minority consumers in that analysis.

Increase access to long-term care in Black communities. And in my opinion that involves two major areas. One is development of a continuum of long-term care services in Black communities and the other is developing a cadre of minority professionals to manage and staff these services.

The Federal Government should provide start-up funds and technical assistance to Black firms and organizations who wish to provide long-term care services in areas such as home care, adult day care, visiting nurse services and residential health care. All of these services are significantly underdeveloped or absent in minority communities. These seem very, very logical choices for grants in minority business enterprises and women's business enterprises.

Long-term care manpower and management are critical areas. One of the ironies of the health care industry is that the majority of hands-on providers are members of racial and ethnic minority groups, especially middle-aged minority women. These women are the backbone of the home care and nursing home industry. For the most part, they work for low wages and poor benefits delivering services to individuals outside of their home communities. Much more needs to be done to train women such as these to be managers and to develop, own and operate their own businesses in the area of long-term care services. Special training programs for this purpose should be developed and supported with Federal funds. There are many excellent models such as the Nursing Home Administrator training program offered by the National Caucus and Center on the Black Aged.

Finally, increase support for families and other informal caregivers. Although policy makers focus more attention on formal and professionally provided health services, it should be remembered that the vast majority of care for sickness and disability is provided by informal caregivers, usually family members. In recent years,

increasing emphasis has been placed on caregiver training and on caregiver support activities which reduce burnout.

It is especially important that Black families, whose resources tend to be much more limited, receive financial, social and emotional support as they attempt to care for their dependent children and elders. Much more attention needs to be paid to development of a family policy at the Federal level which recognizes the cost savings to the public sector attributable to the family provision of long-term care. Modest investments in day services, respite programs and financial assistance perhaps through tax breaks would go far to assure that families are able to continue their caregiving activities.

In closing, I would like to thank the committee for their consideration of these recommendations and note for the record that I have given Diana Jones a copy of a report on minority elderly which was recently published by the New York State Office for the Aging. I think there is some excellent material in the report that your committee might wish to know of.

Thank you.

[See Appendix 2, p. 105 for material submitted by Dr. Morrison.]

[The prepared statement of Dr. Morrison follows:]

LONG TERM CARE NEEDS OF THE BLACK ELDERLY

STRATEGIES FOR ACTION

Testimony of

Dr. Barbara Jones Morrison

Representing the National Caucus
and Center on the Black Aged, Inc.

Prepared for Hearings on the Health Care Problems of the
Black Elderly Sponsored the U.S. House of Representatives
Select Committee on Aging

June 24,1989

Columbus, Ohio

INTRODUCTION

Chairman Roybal, may I begin my testimony by expressing my appreciation to you for extending an invitation to me to participate in these hearings. As you know from previous testimony I have made before your Committee, issues which pertain to the health care needs of the Black elderly are of long standing concern to me.

My remarks will address the health status and long term care needs of the Black elderly. Where available, I have used data from my home state of New York to illustrate the extent or health problems among older Blacks. I have also provided some broad recommendations for action by the Select Committee on Aging- either alone or in cooperation with other interested groups. I would be the first to state that my recommendations are not innovative. In fact, professionals in the health care field, the professional literature, and advocacy and consumer groups have made the same suggestions over the years in a number of forums. They bear repeating today, because progress toward improving the long term health care needs of the Black elderly has been slow.

Health this testimony is used in its broadest sense to mean not just the absence of disease, but creation of a biological, social, and psychological environment in which Black older people can experience a sense of wellness and live the remaining years of their lives to their fullest potential.

Wellness for all persons, including the elderly, is shaped by a multiplicity of factors. These include: heredity, life style patterns, economic status, health behaviors, and access to goods and services which support wellness such as health care, adequate nutrition, decent housing, and social or vocational opportunities which foster a sense of self-worth and self-esteem.

The long term care needs of the Black elderly are shaped by all of these factors. In this testimony, I will offer some broad suggestions for specific actions which might be considered by Federal, State and/or local governments in cooperation with non-governmental entities to address the long term care needs of older Black people.

It is clear in a time of severe fiscal constraints in the public sector that there will be increasing competition for goods and services among racial groups and among age groups. All of the needs cannot be met by the public sector even as it seeks to target scarce public dollars to those deemed "most needy". Increasingly there is a role for the private sector to play in meeting the needs of at-risk and disenfranchised groups such as the majority of Black persons over the age of 65, especially those who are women, live alone, and who are very old.

Growth in the Black Elderly Population

The number of minority elderly are increasing rapidly as an overall proportion of the elderly population. Black and Hispanic elderly are predominant in this group, For example, in January of 1989, the New York State Office for the Aging published a report entitled, Minority Elderly New Yorkers: The Social and Economic Status of a Rapidly Growing Population. It states that " the 1980 census reported 392,000 minority elderly (aged 60+) persons in New York State. The Black and Hispanic aged were the two largest minority groups, and . . . accounted for 90% of all minority elderly persons in the State. The Black aged numbered 237,000- more than 60% of all the minority elderly and 8 percent of the elderly population as a whole". (State Office for the Aging, 1989, pp.9-10).

In New York City, Black elderly represent an even larger proportion of the elderly population. In its report, The Elderly in New York City 1970-1980: Selected Demographic Characteristics by Borough (1982), The New York City Department for the Aging indicated that, "Between 1970 and 1980 the proportion of non-white elderly in the population 65 and over nearly doubled rising from 10 to 18 percent. Black elderly continue to constitute the largest group of minority elderly. In 1980 they were 13.4 percent of all elderly 65 and over." (p.35)

Health of the Black Elderly

Compared to their White counterparts, Blacks experience more illness (morbidity) and death (mortality). This pattern has been well documented in the health literature. For example, a multi-volume report on Black and Minority Health was prepared for the U.S. Department of Health and Human Services which provided ample empirical evidence to this effect. (USDHHS, August,1985)

Life expectancy is one of the most valid and widely recognized indicators of health status. The life expectancy at birth for New York's Black population was 69.7 years, compared to 75.2 for Whites. As a rule, Black women have a longer life expectancy than Black men, and this carries over into old age. At age 65, older Black men can be expected to live an additional 13.4 years, compared to 17.2 for older Black females, 14.5 for older White males. and 18.7 for older White females. (State Office for the Aging [SOFA], 1989,p.22)

These differentials in life expectancy are related to differences in patterns of disease. According to the records of the New York State Department of Health, 133,186 elderly New Yorkers (age 60+) died in 1984 including 12,693 racial minority elderly. Five causes of death predominated regardless of race,

although percentages of the older population dying from these five causes varied by race. For nonwhite elderly (the majority of whom are Black), 43.3% died of heart disease, 23.8% died from various cancers, 6.5% dies from cerebrovascular disease (strokes), 3.7% each from pneumonia and diabetes.(SOFA, 1989, p.25)

Coronary Heart Disease (CHD)

When age-adjusted death rates are examined for CHD, mortality rates are similar for Black and White males, but are greater among Black women compared to White women. Hypertension (high blood pressure) is a major risk factor for heart disease and stroke. The higher prevalence of hypertension among Blacks is well documented in the medical literature which cites both hereditary and social factors as causative.

There is evidence that major public health campaigns undertaken between 1960 and 1980 to combat hypertension are yielding results among Blacks. On a national level, mean systolic pressure for Blacks declined more than it did for whites during this time period. In addition, Blacks were more likely than in the past to be aware of their high blood pressure and to seek treatment. In order for these gains to be sustained, such public education and outreach efforts must be maintained.

Types and Prevalence of Cancer

Statistics from the National Cancer Institute's Surveillance, Epidemiology, and End Results (SEER) Program (1978-1981) indicate the following patterns of cancer incidence among Blacks:

o The death rate from lung cancer is 45% higher among Black males compared to White males, while rates for Black and White women are similar.

o Rates of esophageal cancer are 3 times higher for Black males and 2.5 times higher for Black females, compared to Whites.

o Black women are 2.5 times more likely to die of cervical cancer as compared to White women and Black women experience a 33% excess death from uterine cancer.

Differences in survival rates are striking. For the 25 primary cancer sites, 5-year survival rates for Blacks are better than those for Whites in only 3 sites: ovary, brain, and multiple myeloma(all relatively low incidence cancers.) Adjustments for stage of diagnosis and socioeconomic status reduce differences in survival rates by race. (USDHHS, 1986)

With regard to these patterns, the Report of the Task Force on Black and Minority Health states:

> The scientific literature supports a hypothesis that differences in cancer experience between nonminorities and Blacks may be largely attributable to social and environmental factors rather than inherent genetic or biological differences. This has major policy ramifications for the accessibility, availability, utilization, quality, and continuity of health resources, for example, state-of-the-art cancer screening, detection, treatment and rehabilitation. Other possible contributors include nutrition status and dietary patterns, immune status and function, educational level and attitudes, and awareness of cancer prevention concepts and behaviors; and acceptance of cancer as a real and potential threat. (USDHHS,1985,p.110)

Cerebrovascular Disease

Although stroke mortality among Blacks declined 51% and CHD mortality declined 42% from 1968 to 1982, stroke deaths remained higher for Blacks than for Whites. A greater proportion of Blacks suffer non-fatal strokes which leave them severely disabled. End-stage renal disease resulting form hypertension occurs more commonly in Blacks. Interestingly, Blacks with end-stage renal disease who receive dialysis have a more favorable outcome. (USDHHS,1985,p.110)

Diabetes

The prevalence of diabetes is 33% higher among Blacks as compared to Whites. Data from the National Center for Health Statistics show that the prevalence of diabetes os 50% greater among Black females as compared to White females. Obesity increases the risk of diabetes and Black women are significantly more likely to be obese. The Task Force on Black and Minority health noted that several studies have shown that the complications of diabetes such as blindness and loss of limbs are more common among Blacks.(USDHHS, 1985,p.149)

Lifestyle Factors

Lifestyle factors such as high sodium and high fat diets, smoking, inadequate exercise, abuse of alcohol, and socio-economic stressors endemic to the Black community increase the risk of each of the leading 5 causes of death among older Blacks. Clearly health education and access to early detection and intervention need to be increased for older Blacks whose limited

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incomes, lack of transportation, and limited education prevent them from fully availing themselves of technologies developed to improve physical health.

Nutrition

Nutrition counseling and access to foods of high quality which are prepared to lower health risks are essential for older Blacks. For some older Blacks, the Title III Nutrition Programs offered by the Office for the Aging are a valuable resource. Yet, statistics on minority participation in Older Americans' Act funded programs in New York State, reveal a steady decline in minority participation. The limited income of older Blacks frequently results in purchase of cheaper poorer quality foods. Yet, high quality nutritious foods need not be expensive if the consumer is properly educated with regard to wise food choices. Older Blacks need access to such information, while being encouraged to avail themselves of entitlement programs such as food stamps and SSI which would assist with the purchase of more nutritious foods.

In his chapter, "Nutrition and Mealtime Behavior" in Aging and Social Behavior: An Introduction to Social Gerontology, (1982), Wilbur Watson examined the participation of older Blacks in OAA nutrition programs. He reported that the White elderly are the primary beneficiaries of these programs. He stated further:

> Among the explanations for this situation is a shortage of programs that are financially accessible to the elderly poor and that are not racially discriminatory against Black American and other non-White elderly. For example, it has been shown. . . that when the elderly are both poor and Black, their exclusion from public services in the United States is even more likely than when neither of these factors is present. Poor health, physical disability, fear of venturing into public places beyond the symbolic security of their neighborhoods, and short supplies of low cost public transportation are other factors that help explain the behavior of Black elderly in public places and the suppression of their consumption of meals through congregate programs. . . . (p.274)

Smoking

Smoking is known to increase the risk of heart disease, cancer, and stroke. Cigarette smoking is more prevalent among Black males compared to White males. Although smoking is not as high among Black women, there are trends to indicate that more Black women and more younger Blacks are smoking- this has dire consequences for future cohorts of older Blacks. As public

knowledge of the health risks of smoking has increased, cigarette companies have stepped up their advertisements in the Black media.

Alcohol Consumption

Mortality rates from cirrhosis have declined consistently among all race-sex groups since 1973, but they remain disproportionately high among Black Americans. Overall, the death rate from cirrhosis is nearly twice that of whites and Blacks suffer disproportionately from higher rates of esophageal cancers associated with alcohol abuse. (USDHHS,1985,p.131)

The long term effects of alcohol abuse were clearly visible in a cohort of Black elderly, especially males, observed by the author in a study of Black elderly in nursing homes. Alcohol abuse among Blacks is a very complex problem. Although research is beginning to identify a genetic predisposition toward alcoholism, there is no question that life stressors so common to older Blacks leads to abuse of alcohol. It is the author's opinion that alcohol abuse is a mask for and indicator of severe and persistent depression in older Blacks, especially among older Black males.

Dementing Illness

In addition to the functional declines related to physical diseases, mental impairments in old age are major factors in creating a need for long term care services. Dementia, particularly Alzheimer's diseases, results in cognitive deficits which significantly impair the ability for self-care. Recent epidemiological studies indicate that 50% to 75% of nursing home patients have significant cognitive impairments related to dementia. In addition to nursing home care, a range of services including day care, caregiver support and respite, and home care, is needed for dementia victims still living in the community. The need for such services applies equally to older Black people suffering from dementia and their families.

Poverty

The limited income of older Blacks has a significant and direct effect on their health status. The foregoing discussion on nutrition, is but one example. In 1984 among Black persons 60 years or older in New York State, 40% had annual incomes under $10,000 compared to 23% of older Whites. In 1985, the annual personal income of older Blacks in New York State was $5654. compared to $8,326 for Whites. (SOFA,1989, p.47)

The low level jobs and erratic work histories of many older Blacks, due to a lifetime of disadvantage and discrimination in education and employment, means that they enter old age with lower Social Security Benefits and fewer retirement benefits. Forty-two percent of the Black elderly in New York State depended solely on Social Security and/or Supplemental Security Income (SSI) for their income. One quarter of the Black aged live in poverty with an additional 20% living in marginal poverty.(SOFA, 1989,p.55) Thus nearly half of older Black New Yorkers live in severely deprived economic circumstances.

Poverty has a direct effect on health status. Older people who are poor are significantly more likely to be sick and disabled due to limited access to proper housing, nutrition and health care. The rapidly escalating cost of health care (primary, acute, and long term care), as well as the higher cost of health insurance (public and private)- has placed adequate health care beyond the means of most Black elderly.

Patterns of Health Services Utilization

Research has shown that compared to their White counterparts, Black elderly are less likely to have one physician with whom they have an ongoing relationship. They are more likely to rely on care in emergency rooms and large impersonal hospital clinics. (USDHHS,1985) This pattern of care means that Black elderly have less access to routine and preventive health care, early screening and detection, and health education- of all which can help to prevent or reduce the effects of the major killer diseases among older Blacks. The Black elderly tend to seek care when illness has reached a crisis stage, as evidenced by their longer lengths of stay once admitted to the hospital.

Use of Long Term Care Services

When severe illness or disease is finally detected among older Blacks, they are likely to need ongoing long term (chronic) care. In spite of their higher disease and disability levels, older Blacks have historically underutilized long term care services such as skilled nursing homes, health related facilities, and home care services. Reasons for this underutilization have been attributed to several factors: cultural preferences for family-based as opposed to institutional care of the frail elderly; racial and class bias in both referral and admission to LTC services; lack of long term care service development in areas where Black persons reside; lack of culturally relevant service design; the high cost and low insurance coverage for long term care; and lack of sophistication on the part of Black elderly and their families in gaining access to limited nursing home beds, (Morrison,1982)

In their article, "The Use of Community-Based Services in Long Term Care" (1979), Douglas Holmes, et. al. reported on a survey conducted of home health, homemaker, day care and meal providers in 32 counties nationwide selected to represent the upper decile of counties in terms of minority proportion of ne of the four Federally recognized minority groups (including Black Americans). They found that agencies which serve a disproportionate share of minorities differ significantly on a number of variables from agencies which underserve minorities.

They state that:

> Agencies which have outreach efforts in minority neighborhoods; in which the proportion of minorities on the staff and the Board is commensurate with the county minority proportion; which have provided special staff training on the needs of older minority persons; which have offices in minority neighborhoods; which have administrators who believe that minority representation on the staff is important and which are public, are more likely to be serving proportionate numbers of minority older persons. Proprietary agency sponsorship is consistently negatively-related to services to minority persons; non-profit agencies are less likely to serve minority persons than are public agencies. (p. 397)

Some studies have shown that hospital personnel are the key referring agents for home care services and nursing home services. As such, their understanding of the health and social needs of Black individuals seeking long term care is critical, as well as their biases in making referrals based on ignorance or prejudicial notions about the preferences of older Black persons and their families. To the extent that health professionals prejudge the needs of older Blacks without sufficient input by the older person and family, inappropriate approaches to the delivery of long term care for the Black elderly will continue.

It is particularly important that the frequently cited preference of Black families to "care for their own" be validated as options for care are explored and assessed. Even if this is a family preference, the ability to act on it will depend on competing demands for the family's financial, physical, and emotional resources. Black families must be helped to understand the advantages and disadvantages of different care options, while being helped through advocacy and case management to access needed services.

Financial and Insurance Barriers to Adequate Long Term Care

The cost of health care is high and continually escalating. As previously noted, the average income of most Black elderly is low. They are forced to make constant trade-offs between spending money on health care and other basic necessities such as food, clothing, and shelter. As a result, financial barriers to accessing needed health services are significant. Although health insurance acts to reduce financial barriers to health care, there are racial differences in the level of coverage in both public and private health insurance plans.

According to the report, Health Status of Minorities and Low Income Groups (USDHHS,1985), the poor and near poor are the hardest hit by rising medical care costs, unless protected by health insurance. Even with coverage, nearly all of the individuals with medical expenses above 15% of their incomes were those who had family incomes below 200% of the poverty level. Some of these were Black elderly families or single individuals.

Medicare and Medicaid have helped to alleviate the economic burden of rising health care costs for many Black elderly. The report goes on to note that, "Elderly persons with a combination of Medicare and Medicaid (presumably the most needy) has the highest mean per capita total health charge and by far the lowest proportion of total charges paid out of pocket . . . In 1980 among the elderly, whites spent $342 and blacks spent $186 on average for health care services. For the elderly who has Medicaid coverage, out-of-pocket expenditures were $266 for whites and $86 for blacks." (p.251)

There are, however, racial differences in reimbursement for services under Medicare and supplemental coverage (i.e. Medi-Gap coverage). Such supplemental insurance is critical, especially for the Black elderly who are not Medicaid eligible. Medicaid covers some important health care expenditures not covered by Medicare such as routine physical examinations, eyeglasses and hearing aids, immunizations, and routine dental care. There are efforts currently underway to have Medicare cover prescription drugs such as antihypertensive medications and insulin which are essential for older Blacks. However, to the extent that such drugs are not covered by insurance, older Blacks may forego the purchase badly needed medications because of limited funds.

The implications of these financial pattern for long term care are obvious. To the extent that Black elderly cannot afford and cannot access preventive and routine medical care for their illnesses, their need for more expensive and intensive long term care is increased. The tragedy is that the major crippling and killer diseases of older Blacks are preventable or controllable with early detection and intervention.

Manpower Shortages in Long Term Care

As reported by Holmes and associates, the involvement of minority persons as health and mental health care professionals and managers is key to the adequate provision of health services to Blacks of all ages. Minority enrollment in medical schools and other professional schools such as nursing and social work has been declining in the recent past. Such a trend is very disturbing. Clearly one factor is the increased cost of undergraduate and professional education and the simultaneous decrease in public financial aid for education. Black youngsters are, for the most part, poorly educated in the lower grades reducing their chances of accessing and succeeding in higher education. This is but one way in which the destinies of the Black elderly and younger Blacks are inextricably linked. Blacks of all ages benefit from the adequate preparation of the young to assume responsible positions of service in the Black community.

The long term care needs of the elderly in general, as well as the Black elderly in particular, will not be adequately addressed until sufficient attention is paid to the severe manpower shortages in service areas such as home care and residential health care. When such resources are scare, it is the poor and minority elderly who are least likely to compete for such resources.

Recommended Strategies for Action

Before outlining suggested strategies for addressing the problems noted, it should be recognized that the Elderly Mental Health and Services Development Reform Act of 1988 sponsored by Chairman Roybal addresses many of the strategies suggested herein, particularly outreach and community support services to the elderly with both mental and physical inpairments and their family caregivers.

o Health Promotion and Disease Prevention

• Increase federal funding to local governments and organizations to organize health fairs where health screening and health education activities are offered. Such fairs could focus address:

a. Disease Screening

- Cholesterol levels
- Hypertension
- Diabetes
- Breast examination
- Pap smear

- Colo-rectal cancer detection kits

b. Health Education

- Nutrition and food selection/preparation
- Smoking cessation
- Alcohol and drug use and abuse
- Weight control

c. Referral services for at-risk individuals

Although these may be targeted to the Black elderly, Blacks of all aged would benefit from such programs which are based in the Black community under Black sponsorship.

• Increase federal assistance to local health organizations to develop health screening teams which can go to individual or group settings where at-risk Black elderly are likely to be found. Through early detection and quick referral to appropriate health and mental health agencies, more Black elderly might be spared unnecessary illness and disability.

• Improving the Resources Among Older Blacks to Promote Health

• Encourage state and local agencies to do much more to provide information on entitlement programs which would enhance the income and health resources of older Blacks, for example:

- Food Stamps
- Supplemental Security Income (SSI)
- Medicaid
- Older Americans Act Programs such as
    - o III-C Nutrition Programs
    - o Expanded In-Home Services for the Elderly
    - o Adult Day Care

In New York, the State Office for the Aging and its local affiliates have done a good job of this. But more outreach is needed on an individual basis, as the declining participation of Blacks in Older Americans Act funded programs would suggest.

• Increase Medicare Coverage for Long Term Care Services

Current Medicare coverage for home health care and nursing facility care is very limited and focused on post-acute convalescent care. Longer term health services, where they exist, are funded largely by Medicaid at considerable costs to states. In NeW York, for example, a signficant proportion of the state Medicaid budget is devoted to nursing home care- resulting in trade-offs in meeting health care needs of nonelderly poor.

• Promote Development of Private Long Term Care Insurance

Although many Black elderly rely solely on public health insurance mechanisms such as Medicare and Medicaid, there is a growing private industry in long term care insurance. Black consumers should not be overlooked as a potential market for these products, especially if offered as part of a menu of work-related benefits. It is important, however, that they people understand the limitations of this coverage and get advice on the adequacy of coverage in "long term care" policies currently being marketed to the elderly. Many of these promise more than they will deliver and the elderly need to be educated as to what to look for in the pattern of coverage.

New York is part of a multi-state project funded by the Robert Wood Johnson Foundation to study aspects of marketing, actuarial projections, and coverage patterns for this type of private insurance.

• Increasing Access to Long Term Care in Black Communities

There are two areas which need significant attention: one is development of a continuum of long term care services in Black communities and the other is developing a cadre of minority professionals to manage and staff such services.

• Services Development

The federal government should provide start-up funds and technical assistance to Black firms and organizations who wish to provide long term care services in areas such as home care, adult day care, visiting nurse services, and residential health care. All of these services are significantly underdeveloped or absent in minority communities.

• Long Term Care Manpower and Management

One of the ironies of the health care industry is that the majority of hands-on providers are members of racial and ethnic minority groups- especially middle-aged women. These women are the backbone of the home care and nursing home industry. For the most part they work for low wages and poor benefits delivering services to individuals outside of their home communities. Much more needs to be done to train minority providers to own, develop, and management long term care services targeted to their own communities. Special training programs for this purpose should be developed and supported with federal funds. There are many excellent models around such as the Nursing Home Administrator training program offered by the National Caucus and Center on the Black Aged.

• Increase Support for Families and Other Informal Caregivers

Although policy makers focus more attention on formal and professionally-provided health services, it should be remembered that the vast majority of care for sickness and disability is provided by informal caregivers, usually family members. In recent years, increasing emphasis has been placed on caregiver training and caregiver support activities which reduce burnout.

It is especially important that Black families whose resources tend to be much more limited receive financial, social, and emotional support as they attempt to care for their dependent children and elders. Much more attention needs to be paid to development of a Family Policy at the federal level which recognizes the cost savings to the public sector attributable to family provision of long term care. Modest investments in day services, respite programs, and some financial assistance (perhaps through tax breaks) would go far to assure that families are able to continue their caregiving activities.

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Ms. OAKAR. Thank you very much. I am sure we will want to see that.

Our next witness is Cheryl Boyce, who is our Director of the Ohio Commission on Minority Health. Cheryl, please proceed in whatever way is most comfortable.

STATEMENT OF CHERYL A. BOYCE, EXECUTIVE, DIRECTOR, OHIO COMMISSION ON MINORITY HEALTH, COLUMBUS, OHIO

Ms. BOYCE. Congresswoman Oakar, it is a pleasure for me to be here to share with you the findings of the Ohio Commission on Minority Health and concerns of the State of Ohio.

The road to today has been long and arduous as we have spent a number of hours doing research, receiving testimony from Ohioans over a period of 30 days and we have invested numerous hours in deliberations.

As a health care professional, I am always torn between whether to cite the date, to cite the literature or whether to share the pain and anguish that we have seen in communities throughout the State. I always opt for the latter.

It is very difficult for data to reflect how much of a sacrifice people in the minority community have made. It is very difficult for numbers to quantify the loss of life, the pain and suffering that we have seen in the community whether in the issues of infant mortality or issues or older Ohioans. It is disturbing to me that we view health care issues in categorical, fragmented manners. We base our review and analysis on criteria such as age, gender or disease entity. The reality is that dead is dead.

In low-income Black communities what affects one member of the household affects all members of the household in a very personal and real way. So when we talk about health care issues of older Ohioans, we talk about health care issues of all Black Ohioans.

We saw six disease conditions and entities that resulted in excess death and morbidity for Blacks who reside in the State. I have tried to tie all but one into this conversation because the sixth one is infant mortality and it would take more hours than I have to try to explain why in the shadow of some of the finest medical facilities in this country Black babies continue to die at alarming rates.

As a backdrop, I want to tell you that the information shared today is a result of the Ohio Governor's Task Force on Black and Minority Health. In 1986, Governor Celeste impaneled a group of 21 people capably cochaired by State Representative Ray Miller and Dr. Ronald Fletcher, who now serves as the State Director of Health. We were appalled at the scarcity of data relative to minorities in this State, and as I have traveled to other States in this country, the scarcity of data is inexcusable and intolerable. It is very difficult to quantify problems when you do not have a data base to start with.

We decided to take the collective strengths of the minority community and try to identify the problems in a different way. In August of 1986, we went to eight metropolitan areas conducting public hearings, 2,000 minority Ohioans attended those public hearings and shared from their vantage point not only the problems in

the community, but the solutions. So rather than cite the data today, what I want to do is to share those solutions as identified by the people in the minority community in Ohio.

By 1987, the Ohio Commission on Minority Health was established, again based on those recommendations, and funded for $3.4 million of State money, which we have reinvested in the minority community to look for solutions in a culturally sensitive and specific way as identified by people who reside throughout low-income communities in the State.

The five disease and conditions come as no surprise. They are diabetes, cardiovascular disease, cancer, issues of violence and substance abuse. They permeate all age segments of the population in this State.

The risk factors; smoking, drinking, poor nutritional status; the problem of lack of health maintenance and access to health care; the reality that most health care material is not culturally specific nor sensitive and pretty much goes over, around or beyond the community because it is not designed for us nor targeted for us are some of the problems that have contributed to the disparity.

My written testimony cites many facts that I have found in reports issued by the group sponsoring this conference and many other people. I share the concern that progress has been too slow.

A primary concern to me is one of caregiving, and the reason it is, because in Black communities we very seldom opt for institutional care and when we do it is as a last resort. While the literature repeatedly cites that caregiving is often done by a daughter in the home, the community tells us, and what we see in the community—and unfortunately by the time we see these patterns from the community at the State and Federal level, we are 20 years removed from the problem.

Ms. OAKAR. That is right.

Ms. BOYCE. The reality is that in minority communities, the caregiver is often the granddaughter because the daughter has died. The granddaughter is caring for her grandmother because the mother has expired or become disabled because of these diseases and conditions. And so we have a cyclical effect going on where the caregiver often expires before the person that care is being given to.

Our mothers and aunts and grandmothers have carried this society on their backs, on their knees scrubbing floors, cooking in kitchens and to stay in the home there is no source of support. People almost have to divest themselves of all sense of dignity in order to get short-term care. So there is no interim period for the elderly in a community setting.

I think it is also worth noting that as people came out and testified in the public hearings, what we also found besides the fact that a mother was—or a caregiver, a younger caregiver, was in the home providing for the older person, because of the history of lack of care for young people in this society, we also often found that there was a disabled child in that home. So that person was not only caring for an older person, they were also caring for a person who might have been mentally incapacitated, physically disabled, without a resource base and without a support network. That is an

awful lot for one person to carry without any kind of resources available to them.

It does not make sense to me that we can provide for institutional long-term care but not episodic in-home care, respite care, some relief for the person. It would be more cost-effective to support the community-based services, and that is a real concern for us.

Many citizens lamented about the dilemma of the spend-down programs from Medicaid, the need for short-term assistance, medication that was halved because people could not afford to pay for a medication regime. So if we know that much of the health care cost is going to cardiovascular disease, if we know that much of the care is going to people at the tertiary level in health care, why can we not redistribute those dollars to invest at the primary and secondary level, which makes more sense in terms of being cost effective. People cannot afford medication, they end up having strokes and then we support them in the hospital. It would have been a lot cheaper to give them the money for the prescription.

One service that was cited repeatedly, nutrition, is a risk factor regardless of age for many of these diseases and conditions. One of the things we heard continuously in all the communities is that we have Meals on Wheels and other home delivery programs that are not culturally sensitive nor specific. Often for people who reside in the communities, those hot meals are the only meals that are available to them during the day, and for someone who is 80 years old, it is a terrible time to start trying to introduce a new dietary regime. Half of the food delivered through these programs are not consumed because they are not known nor prepared in a way that people in the community are used to ingesting it. So it makes little sense to me that we have these programs, they look like they succeed because we have numbers as outcomes, but they are not making the impact in terms of a better status of health for Black populations.

Substance abuse was cited repeatedly—not surprisingly was alluded to during our hearings. We know that late onset alcoholism and abuse of drugs, usually prescriptive drugs, are often a concern. Usually the elderly will only seek care or admission for treatment if they are referred by a family member and encouraged to go. We also know that there are late life stresses including failure of an elderly person to adapt successfully to late-life events such as retirement or loss of spouses, but we also know that Blacks are overrepresented in mental health facilities, institutional care and underrepresented in terms of community mental health services.

We are concerned about the fact that mental health services are not culturally sensitive nor specific and that is a problem that exists in most States, and it is part of the nature of the problem in that particular discipline. Cross cultural training and geriatric mental health training seem to be in order.

For the elderly person who lives independently, the uncertainty of life clashes with the certainty of violence. The homicide and suicide rate are increasing in Black populations. There used to be an old saying in the Black community that Blacks do not commit suicide. Well we do now.

For people who live in the community, they have become easy prey because we have created clusters of people, a homogeneous

population, and the fear is real. People are afraid to go out on the street and shop, people are afraid to visit friends. So the isolation is almost fostered by the physical setting that we thrust the elderly into.

The Ohio Commission on Minority Health has funded numerous projects with the $3 million that the State has allocated. In April we funded Minority Health to mount a 30 day intensive campaign throughout the State focusing on the elderly, focusing on Black males, focusing on children. Those programs were planned at the community level and implemented in community settings. The response was phenomenal but it was probably because the bureaucracy put the money there and then we remove ourselves and let the community do their thing.

Two projects that were funded during the biennium that I want to share just an overview of was Outreach and Assessment to the Older Minority Alcoholic Project, which was funded in Cincinnati and has served 150 older Ohioans for chemical dependency. That program, like many of the programs that we know work in the community are time intense, one-on-one, build trust and respect kinds of programs where people out of the community are trained and employed to do one-to-one outreach services on the same model that we used in the 1960s, a successful model that was discarded not because it was not effective but because it was not seen as a revenue generating center. Programs that work and are successful in Black communities you cannot bring them in a group for 2 hours, sprinkle them with some information and miraculously attitudes and behavior change. We know that the Black community does not buy the disease theory of alcoholism, therefore we are not going to buy the treatment models that are based on that theory. We need to look for new, innovative ways.

In Cleveland, we fund Project Go, which is a diabetes and cardiovascular awareness program. Project Go has taken street health workers and put them through an intensive training program. They go one-on-one into the home, they provide self-care skills and techniques, they provide the conduit between the health care delivery system and the social service delivery system. It is case management at its finest, it does not involve professionals and it has been a workable model.

We need to start looking at the strengths of the minority community as strengths and utilizing those to develop models that may not fit traditional service delivery but that will impact to improve the quality of life. We can also look at—some of the recommendations that I would like to make would be to:

(1) Look at strategies for marketing which have been extremely successful. The alcohol and cigarette industries have proven that you can target and pluck out populations of people and reach them. The Black population, blue-collar workers have been targeted by these industries. We need to be bold and visionary and take the successful component parts of those marketing campaigns and implement them. Unfortunately I can point out more marketing strategies for marketing illness to Black people than marketing wellness. So we can extract component parts and use them. People cannot tell me marketing does not work or the soap industry would not be as competitive as they are with which soap product we use.

We need to be bold and visionary. This year we celebrate the advent of frozen dinners. At the time that frozen dinners were introduced, there were indicators that would have suggested that there was no way that product would have made it. Only 15 percent of the American public had freezers in their home at the time Swanson introduced that product. Somebody had a vision, but better yet, somebody had a plan.

I celebrated my 40th birthday last week. I know that I am getting older. I also know that because my generation bought into zero population growth, that there are going to be more of us at my end of the spectrum than people supporting us at the other end of the spectrum. So I have a vested interest in us looking long-range to solve some of these problems.

But we need to be bold and visionary and look at indicators and not be intimidated by global pictures for solution.

I agree with Dr. Morrison, prevention has to be a key. While there are some conditions that are inherent with growing older, a lot of the situations that have affected older Black people were preventable. We need to prevent those things that we can prevent and we need to make a sincere commitment to doing that.

In the 1960s there was a focus toward fitness toward children in the school system. Walking to school has been replaced by school buses. People preparing meals at home that were nutritious and nutritiously prepared have been replaced by the fast fix, fast food industry. We are growing an industry of children who are going to have a health status that looks far worse than this generation of older people, and we need to address those problems by redirecting dollars. Appropriations have to go along with all of the legislative actions that are proposed. The community cannot do it for free.

Community based assistance must be an integral part of the plan. I am not going to go through all of this because I know that I have gone over my 5 minutes.

Ms. OAKAR. Well you know what we can do, Cheryl, is—your statement, along with the others is very, very interesting, but I would certainly want to have all the material you have for our record.

Ms. BOYCE. In the packet that we have given you, the report that we issued on the health status of Ohio is there and I think there would probably be a ditto mark for any State with a high minority population.

One statement I would like to echo with Dr. Morrison. There has to be something done about increasing the minority health professional pool. Programs like the National Health Services Corps no longer exist and we know that people seek care from health care providers of their own racial and ethnic background, and we know that physicians and other health care providers of color provide a disproportionate amount of uncompensated care. So it becomes real critical to our community's survival that we somehow stimulate and increase opportunities to get health care professionals trained.

Thank you for the time and the opportunity to share this.

[The prepared statement of Ms. Boyce follows:]

Richard F. Celeste
Governor

COMMISSION ON MINORITY HEALTH

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Testimony

U. S. Congressional Select Committee on Aging
The Honorable Edward R. Roybal, Chairman

Hyatt Regency, Columbus, Ohio
June 24, 1989

Presented by Cheryl A. Boyce, Executive Director
Ohio Commission on Minority Health
131 North High Street, 4th Floor
Columbus, Ohio 43215

Mr. Chairman and distinguished members of the Select Committee on Aging, I am extremely pleased to have this opportunity to present issues of concern pertinent to Black, elderly Ohioans.

The road to today has been a long and arduous journey involving numerous hours of research, receipt of testimony from minority Ohioans and deliberations.

I am Cheryl Boyce, Executive Director of the Ohio Commission on Minority Health. The Commission is the first concerted effort by any state to address remediation of the disparity in health status which exists between majority and minority citizens.

The Report of the Secretary's Task Force on Black and Minority Health, Department of Health and Human Services (1985) pointed out that, "despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks have not benefitted fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology.

In February 1986, Governor Richard F. Celeste appointed a 21 member Task Force capably co-chaired by State Representative Ray Miller and Dr. Ronald Fletcher to examine this disparity in health status and to make recommendations to remediate the disparity.

Five diseases and conditions account for a significant number of excess disability or death among the aged Black population:

- diabetes;
- cardiovascular disease;
- cancer;
- violence; and
- substance abuse.

Several Factors contribute to the disparity:

- risk factors, e.g. smoking, drinking, poor nutritional status;
- lack of access to health maintenance;
- a lack of culturally relevant health promotion materials and campaigns targeted to Blacks;
- and a lack of access to care and treatment when the prognosis for positive outcome is optimal.

In 1987, the Ohio Commission on Minority Health was established by Amended Substitute House Bill 171 to address these problems based on 12 recommendations from the Governor's Task Force. Chaired by State Representative Miller, the 18 member Commission is funded for $3.4 Million of state funds.

Much of the information presented to the Select Committee today is excerpted from testimony provided by elderly Black Ohioans and their care givers at eight public hearings conducted statewide.

While I am sure that you will be inundated with similar information during these proceedings, I will highlight several points as a backdrop to my testimony.

- The status and resources of many elderly Blacks reflect social and economic discrimination experienced earlier in life. Consequently, increased risks of poor education, substandard housing, poverty, malnutrition and generally poor health results.
- Health care assistance is a significant concern. Language and cultural differences along with physical isolation and lower income limit access to health care services.
- Admission to a Nursing Home is usually a last resort. Most minority elderly remain in the community and are cared for by family, friends and relatives.
- Elderly Blacks are more likely to have experienced periods of unemployment due to discrimination and other causes. Not only do Black men accumulate less work experience, they also are likely to leave the work force earlier, often due to poor health status.
- Blacks are less likely to accumulate income, other assets, benefits or pensions. Consequently, they have less personal post-retirement income and are more dependent on Social Security benefits for the majority of retirement than whites.
- Sharing a home with a grown child, usually a daughter, is a common living arrangement for older adults.

Issues of elderly Blacks should permeate and cross cut systems of service delivery relative to housing, medical/health services, mental health and other human service systems. Realizing that much has been stated, recorded and reported about the status of the Black elderly in the United States, I acknowledge and concur with the comprehensive findings of the 1987 Report of the National Caucus and Center on Aged for the Select Committee, which addresses a myriad of valuable issues. Rather than repeat these, I offer the following community-based concerns.

It is disturbing that we tend to view health care issues in a categorical, fragmented manner. We base our review and analysis on criteria such as age, gender, or disease entity. The reality is that in low income Black communities, what affects one member of the household, affects all members of the household in a very personal way.

In general, the Black community is receptive to maintaining "it's own" within the community setting. While this decision is a vital aspect of the culture, it can also be attributed in part to less disposable income, which translates into fewer options for decision making.

- The caregiver is often female and within the childbearing years. It seems less a rarity than a reality that the so called sandwich generation is not a new situation for Blacks. Additionally, the frequency of there being a physically or mentally handicapped child residing in a familial group which provides various levels of care for an elderly person, is a common occurrence. If there is a differing view from that cited in the literature, it would be that often granddaughters "inherit" the responsibility of care upon the demise or incapacitation of their mother, creating a cyclical effect.

  The person who provides long term care is also at risk. They frequently experience isolation, confusion, depression, fear, lack of support, economic hardship and personal illness. The diseases and conditions which negatively impact Blacks do not manifest themselves overnight. A caregiver may feel as though she is looking into a mirror. The onset of her recently diagnosed diabetes may be occurring as her mother or grandmother experiences an amputation. Her diagnosis of hypertension may be simultaneous with the occurrence of a stroke. The diagnosis concurrently of same site cancer within the household is not a rarity.

  These caregivers are often low income or on fixed incomes themselves. The drain on their financial resources are not supplemented for community-based assistance, including but not limited to respite care or short term stays in Intermediate Care Facilities, short of divestiture of resources.

- Numerous citizens lamented the dilemma of meeting the spend downs for Medicaid; the need for short term episodic assistance, when none was imminent; the need for information or identification of the appropriate agency, but getting the bureaucratic shuffle; the high cost of medications prescribed for daily use, but which were rationed over the course of a month due to a lack of resources.

- One service which is provided in the community, but was repeatedly cited, pertained to nutrition, a major risk factor. Much of the testimony pertained to in-home food delivery. For many, this is the only meal of the day; however, the program is not perceived as being culturally appropriate. Repeatedly, we were told of food items which were not "known" or generally consumed by Blacks and about food preparation methods which made ingesting the meals unappetizing. Dietary patterns established over a lifetime do not change instantly and without more than just a delivery program, it is doubtful that an attempt would be made. Statistically, such services meet their goals, but do they have the desired impact?

- Substance abuse in elderly populations not surprisingly, was alluded to during the hearings. Late onset alcoholism and abuse of drugs, often prescriptive, have been acknowledged in the literature as unacknowledged problems. Concern of family and friends are the most common factors motivating the elderly to seek admission. The reasons for late onset abuse are varied, triggered by late life stressors including; failure of the elderly person to adapt successfully to late life events, such as retirement or loss of a spouse.

- Black Ohioans are, in general, over represented in Mental Health institutions and under represented in community treatment programs. The problem is exacerbated for the elderly. The percentage of older adults needing care exceeds that of the general adult population. While many can be successfully treated on an outpatient basis, they will receive little or no treatment from the mental health system. Services must be designed and provided in a manner that respects sensitivity and awareness of ethnic and cultural differences. The training of mental health professionals must be redirected to include cross cultural and geriatric mental health training.

- For the elderly who live independent, the uncertainty of life clashes with the certainty of violence. They often fall easy prey to con artists and have gotten caught in the cross-fire of the CRACK industry. We assist them in their vulnerability by clearly setting them apart in nonsecured senior citizen housing. This residential arrangement, while more affordable, also encourages isolation and a clustering of a homogenous population. Usually located in low income communities, there are often limited options for grocery shopping, safe areas to walk, etc. Our concept of independence may indeed foster dependence.

Demonstration Projects Funded
by the
Ohio Commission on Minority Health

Many of the demonstration projects funded by the Commission include services for the elderly. Two of the 37 projects were specifically designed for older citizens.

Outreach and Assessment to the Older Minority Alcoholic, is a project providing services in Cincinnati.

Substance abuse is not age, race of sex specific. While there is proportionate representation of other groups in alcoholism treatment, there exists a glaring disparity in the number of adults age 55 and over for whom intervention, rehabilitation or aftercare programs are available. This extremely high risk population has, for the most part, been unidentified, untreated or inappropriately treated and unsupported relative to their substance abuse problem and needs.

The project has provided an intensive community-based outreach effort to identify 150 older adults with chemical dependency problems, and to insure continuity of intervention services. Additionally, it is designed to decrease the frequency of misdiagnosis, inappropriate treatment and relapse, by providing education and treatment to 250 health and human service providers.

Diabetes and Cardiovascular Awareness, provides services in Cleveland. This project employs community residents, street health workers, to provide direct service interventions which include: assessing and developing socio-health care plans for older clients; on-going training initiatives to impart self-care and disease management techniques; screening 500 older clients for undetected diabetes, including on-going monitoring for clients diagnosed with these conditions.

Under this grant, the project developed and produced, "Seniors at Risk Tapes", which are used at in-home education/discussion sessions.

The use of known, trusted community members as outreach staff has enhanced the utilization and acceptability of this project. In addition to the door-to-door initiative originally proposed by this project, other providers in the area have joined the effort by scheduling mobile units into areas of high concentration.

The purpose of the Commission's grant program is to allow providers an opportunity to develop innovative, culturally specific programs which may demonstrate significant impact. The first full grant cycle is just ending; however, many of the projects have convinced us that the manner in which services are traditionally planned and delivered must be assessed. Shared responsibility and participation of those proposed to be served, the community at large, the public and/or private sectors, increases the likelihood that services will have a meaningful impact.

Recommendations

1. **Utilize Strategies of Marketing Which Have Been Extremely Successful.**

   The cigarette and alcohol industries have proven that groups can be targeted, plucked from the general population, for information and behavioral change. In spite of using high tech mechanisms, they rely heavily on one to one contact (street distribution, give-aways, direct mailing) to promote their product. One to one contact is a critical element in reaching Black populations.

   We must be bold and visionary in our approach. A classic marketing design is exemplified by the current celebration of TV dinners. At the time of introduction into the marketplace, only 15% of Americans had freezers in their home; most cooking was still considered to be from scratch, and many women still worked in the home. The indicators did not suggest success. Someone had a vision - better yet, there was a plan.

   Unfortunately, there are more such examples for successful marketing targeted to Blacks which promote illness than those which promote wellness.

   We know that the segment of our population which is growing rapidly is the elderly. My generation bought into varying degrees of the zero population movement. Quite frankly, without visionary long range planning, I fear what the future holds.

2. **Prevention Must Be A Key Element In A Long Range Plan.**

   There was a time that targeting positive behaviors for our children was paramount. An example was school-based physical fitness programs, which are now considered extracurricular activities. Our children are overweight and lethargic. School buses have replaced the long walks to school, fast foods have replaced in-home food preparation. By the time these children are older, it won't take a health practitioner to forecast their health status. The conditions associated with aging will never be eliminated, but the preventable should be prevented. Education, information and development of effective prevention strategies are necessary.

3. **Community-based Assistance Must Be An Integral Component Of The Plan.**

   It is cost effective to provide subsidies and/or incentives to assist older adults or caregivers in the community. Programs to insure the availability of respite care, a mechanism to assure institutional care on an as needed basis and/or home-based nursing services should be developed.

4. **Increase The Number Of Minority Health Professionals.**

- **Numerous studies have documented that physicians treat more patients of their own race and ethnic group. Minority physicians have a greater service obligation in responding to the health care needs of aged poorer and younger Blacks, when compared to other medical school graduates.**

  The Ohio applicant pool for minority students continues to decrease. Additionally, the National Health Services Corp. (NHSC), a federally funded scholarship program, is being reduced.

  NHSC financed physician education and placed physicians in medically underserved areas. By 1990, the number of placements in Ohio will dwindle, threatening the supply of clinicians available to provide medical services to low income populations.

  Approximately 20 percent of the NHSC physicians assigned to Ohio were minorities.

  According to the Association of American Medical Colleges, between July 1983 and June 1984, of Ohio's reported medical school graduates, only 39 were Black, 36 Asian/Pacific Islanders, 4 Native American Indians and 10 Hispanics.

  The under representation of minorities in the medical profession will become more dramatic in the future, thereby impacting negatively on the availability of practitioners to minority populations, unless a comprehensive plan is developed to increase the number of minority health professionals.

  This under representation permeates the health professions, including nurses, health educators, psychologist, nutritionists, speech pathologist and audiologists.

  A mentorship program between minority health professionals and students could facilitate recruitment and retention for health care occupations.

- **Professional schools supported by the state should establish a minority scholars chair to develop and coordinate curriculum on minority health and cultural issues to improve health status.**

  To improve the acceptability of health services to the minority community and the availability of culturally sensitive providers, cross cultural training should be included in academic curricula. It is imperative that students be made cognizant of the special needs of minorities, problems of minority populations and cultural differences and geriatric issues, as a part of their formal training.

- **Develop a cultural competency curriculum, fund research and develop a training site for outreach workers and health professionals.**

  Health care professionals need to know significant aspects of diverse cultures in order to provide treatment regimes and information which are acceptable to minority citizens.

  It is not practical to expect that a training location could be established in every state in the nation. It is feasible to establish regional sites to accommodate the training needs of professionals and paraprofessionals.

  Information should include a historical perspective of various minorities and their beliefs and practices which might be in conflict with traditional health care models and proposes program designs based on cultural diversity.

5. **Improve Computerized Management Information Systems Which Will Identify and Measure Minority Health Data Such As:**

   - A) Vital Statistics;
   - B) Morbidity;
   - C) Utilization; and
   - D) Diagnostic Groups or Categories.

   - **Vital Statistics**

     There is a paucity of health related data relative to minority populations.

     The lack of race and ethnic specific data is the most consistent obstacle in determining the degree of disparity in health status for the Hispanic and Native American communities.

     Hispanic is an ethnic, not a racial identifier. Hispanics are reported as Whites in vital statistics reports; therefore, it is difficult to ascertain mortality trends specific to that population.

     Data reported in the categories of White, Black, Hispanic, Native American, Asian/Pacific Islander and Other, would allow analysis of health status and serve as a significant planning tool for health care providers.

   - **Morbidity**

     Most health related information is retrospective, based on mortality information.

The potential for collecting prospective data based on morbidity would provide information to establish patterns of incidence of disease and afford an opportunity to plan services in accordance with needs for delivery of health services.

Model: MATCH I and II Program (Ohio Department of Health, Maternal and Child Health) was funded in 1983 by a SPRANS (Special Project of Regional and National Significance) grant. The system is used to design and implement a useable primary database of funded MCH projects and to function as a management information system for clinics and state agencies. MATCH II is a MIS cross linked between departments of state.

- **Health Care Utilization, Diagnostic Groups**

Utilization patterns for preventive health services, frequency of diagnosis and utilization of primary/secondary services are difficult to verify. Determination of diagnosis, hospital and health care professional utilization and diagnostic information would indicate the rate at which minorities were accessing public health services and the facilities/practitioners who provide services.

Ms. OAKAR. Thank you for an excellent statement, and I look forward to giving you a couple of questions here.

Our next witness is Mr. Roland Hornbostel, who I have known for many years. Actually somehow we lost him, he was in Cleveland for a long time and now he is doing such great ombudsman work for the State. This program is really important because if you do not have ombudsmen—you might say well what does that do, you know, I know in nursing homes, we unfortunately have had so many nursing homes in our country that are very substandard and they are in particular substandard levels in the Black community whenever we have them, and low-income whites as well. And I just wanted to say to you because you are in a position where you are the only male on a panel, you know, it is very rare that we see that, but I wanted to say that you have done some wonderful work that I personally know of and we are delighted to have you here.

STATEMENT OF ROLAND HORNBOSTEL, STATE LONG-TERM CARE OMBUDSMAN, OHIO DEPARTMENT OF AGING

Mr. HORNBOSTEL. Thank you very much for your kind words, Congresswoman Oakar. The ombudsman program in Ohio which I represent handled about 9,000 complaints about Ohio nursing homes last year through representatives of our 12 regional offices.

This morning I would like to talk about two particular concerns, one is, not surprisingly, long-term care and the other is something that we have not talked a lot about this morning but I think we need to, and that is the effects of the Medicare Catastrophic Coverage Act on the Black elderly. So I want to address that as well.

First of all, in regard to long-term care, Ohio's Black elderly population is three times more likely to use community based long-term care services than they are traditional nursing home services. Now there is both a good and a bad aspect to the reason for what I think is a fairly astounding statistic.

Let me share with you though first of all the bad aspect of why I think that occurs. Racial discrimination in nursing home placements still exist in Ohio and in fact throughout the Nation as a whole. Dr. Morrison alluded to that and I am going to mention it as well. Years ago when I was in Cleveland, back in the middle 1970s, it is no secret that in half a mile area there were two nursing homes, very large nursing homes. The make-up of one nursing home population was almost entirely white, the make-up of the other nursing home was almost entirely Black. Clearly, while we have made some in-roads into that problem, we do have civil rights laws and I am happy to say that we have an Office of Civil Rights Compliance in Chicago that has been in Ohio aggressively enforcing these laws, this problem still exists.

But the fact remains that—

Ms. OAKAR. I want to say that the way the Supreme Court is acting—not with the last two, but the three that relates to women and minority decisions, is totally repugnant and I do not mind saying this for the record. It is a real slap in the face against women and minorities, and I will tell you, we are going to have some battles about hanging onto what we have——

Mr. HORNBOSTEL. Amen.

Ms. OAKAR [continuing]. In the future. I did not mean to interrupt there, but when you talk about protection and civil rights laws——

Mr. HORNBOSTEL. That was a worthy interruption and certainly something that I totally support.

In fact, in the overall elderly population one expects, from research that has been done, that about 5 percent of the elderly are in need of long-term care in a nursing home setting. Contrast that, if you just look at Black elderly, 3 percent are represented in that population. But an even more astounding statistic occurs when we look at what has happened with community based long-term care in Ohio.

In Ohio we operate in 12 counties currently a Medicaid waiver program called PASSPORT that provides intensive long-term care services and case management services to people in their own homes who otherwise would have to be in a nursing home. In fact, that is the criteria to get onto the program, you must be in need of nursing home care and you must be actively seeking nursing home care. In the State of Ohio about 10 percent of our nursing home population is Black. In the PASSPORT program—and bear in mind that numerous counties in the PASSPORT program are rural counties—the Black participation is 30 percent, 300 percent of the people receiving long-term care in institutions.

The good aspect of that is because we think PASSPORT and programs similar to it that provide for long-term care in people's own homes respect Black family values. We think that this is an important thing that as we—and you should know that depending on how the conference committee comes out this weekend—we think we will be expanding PASSPORT to 100 percent of the State of Ohio during the next year, that we think that that will be a long-term care system in this State that will far more respect values that we hope the general Ohio population will learn from you folks. So we are real pleased to say that we are going to expand that program.

Let me move on also, and talk a little bit about the Medicare Catastrophic Coverage Act. There has been a lot of debate over the Medicare Catastrophic Coverage Act in Washington, D.C.—I think that is probably putting it mildly, Congresswoman Oakar.

Ms. OAKAR. That is for sure.

Mr. HORNBOSTEL. And I think a lot of that debate has resulted from people who perhaps have accumulated some wealth, complaining about the premium surcharge and so forth. And I think that at one level they may in fact have some valid concerns, but I do want to say something about two little known provisions of the act that if we are going to tinker with the Medicare Catastrophic Coverage Act, I hope we do not lose these two particular benefits because they are potentially the two most beneficial aspects of the Medicare Catastrophic Coverage Act for minority elderly.

The first is a new concept called Qualified Medicare Beneficiary. Congresswoman Oakar said it in her opening statement and you have heard it from other panel members before, but the fact is that particularly Black elderly women are less likely to have entitlement to Social Security than the general population, and even if they do that entitlement is likely to be lower. What the Qualified Medicare Beneficiary provision does is provide that during a phase-

in period of the next 5 years, the State of Ohio must extend Medicaid benefits to people who are below the poverty level. And one thing we know is that currently 32 percent of Black Ohioans live below that poverty level. What that in effect does is eliminate the need for people who fall into that category to have private Medicare supplemental insurance. We think it is an important new benefit and one that should be preserved.

The second thing that I would like to mention is the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act. Right now when somebody enters a nursing home, they have to spend-down their entire life savings and frequently that of their spouse who still resides in the community. What the spousal impoverishment provisions of the Medicare Catastrophic Coverage Act will do is allow community spouses to keep at least $12,000 in assets and also be entitled to a contribution from the institutionalized spouse to bring them to 122 percent of the poverty level in terms of income. We think that these are important new provisions and we hope that they do not get lost in the debate over the Medicare Catastrophic Coverage Act.

But the final problem with the Medicare Catastrophic Coverage Act is that it does not really address the long-term care needs of older Americans. Your late colleague, Senator Pepper, recognized this I think more than any other individual. With his passing, I urge you and the other members of the committee not to lose sight of his laudable goal for which he strived these last few years. He knew that older persons were in greatest need of protection from the devastating effects of long-term illness. He sought new expansions in community-based long-term care benefits in Federal programs. Perhaps the most fitting tribute that you and other members of the committee could give to Senator Pepper would be to realize his vision of a long-term care system that provides care to elderly persons in their own homes.

I thank you for your kind attention to these remarks and I look forward to your questions.

[The prepared statement of Mr. Hornbostel follows:]

TESTIMONY OF ROLAND HORNBOSTEL, OHIO LONG TERM CARE OMBUDSMAN

HOUSE SELECT COMMITTEE ON AGING

HEALTH CARE PROBLEMS OF THE BLACK ELDERLY

COLUMBUS, OHIO

My name is Roland Hornbostel. I am currently Ohio's Long Term Care Ombudsman and oversee the long term care ombudsman program which is a division of the Ohio Department of Aging. I have been employed by the ombudsman program for the last twelve years.

In Ohio, the ombudsman program consists of twelve regional offices that respond to complaints filed by or on behalf of the residents of long term care facilities. In this past year, representatives of the ombudsman program have investigated almost 9000 complaints filed with the program in regard to care and services delivered in nursing homes and other adult care facilities. The complaints run the gamut from abuse and neglect to the simple inability on the part of elderly consumers of long term care to access our fragmented system of care.

I am pleased to come before this committee this morning to testify on two particular concerns that affect the black elderly population in Ohio based on my observations as an ombudsman. First, I would like to address the current imbalance in Ohio between institutionally-based and community-based long term care. Secondly, I know that there is much current debate in Washington over potential revisions of the Medicare Catastrophic Coverage Act of 1988. In the midst of that very important

discussion, I would like to draw attention to two of the lesser known provisions of that Act that particularly benefit the black elderly.

I. OHIO'S BLACK ELDERLY POPULATION IS THREE TIMES MORE LIKELY TO USE COMMUNITY-BASED LONG TERM CARE SERVICES THAN TRADITIONAL NURSING HOME SERVICES.

By way of background, the Ohio Department of Aging operates a 2176 Medicaid waiver program, called PASSPORT, in twelve counties. As part of Governor Richard Celeste's Eldercare initiative, we will be expanding the PASSPORT program to all of Ohio over the course of the next year. The PASSPORT program is a true alternative to nursing home care in that potential enrollees are required to be actively seeking nursing home placement and must need the level of services that a nursing home provides either at the skilled or intermediate care level. An analysis of those enrolled in the PASSPORT program reveals that 30% of those served are Black. At the same time, only 10% of Ohio's nursing home population is Black. Nationally, 3% of the black elderly populations is in a nursing home compared to 5% of the white elderly population despite the fact that the black elderly are less likely to be in good health. I believe that this results from two very different factors.

A. Racial discrimination in nursing home placement still exists in Ohio, and, in fact, throughout the nation as a whole.

While I believe that we have made important inroads toward ending discrimination against individuals in need of nursing home placement on the basis of race, such discrimination still exists. I can remember in my early days as an ombudsman in

Cleveland that there were two homes less than a mile apart. In one nursing home, the resident population was virtually 100% white, in the other the population was virtually 100% Black. Thankfully, this practice has ended, and I would like to believe that the ombudsman program played some role in halting this deplorable practice.

However, we still find that Blacks face difficulty in gaining admission to some nursing homes. Sometimes, this is due to the larger problem of discrimination by nursing homes against those on Medicaid. Discrimination against persons seeking nursing home admission on the basis of source of payment has created a discriminatory impact on the basis of race.

Sadly, many black Ohioans seeking admission to a nursing home find that they will be relegated to nursing homes that are substandard, provide inadequate care, and have severe staff shortages. Yet, I know that there are good nursing homes in our urban centers. Clearly there needs to be more emphasis on the development of quality nursing homes in our inner cities that provide services to all without regard to race, color, creed, national origin, or source of payment.

B. Black elderly Ohioans have voiced a clear preference to receive long term care services in their own homes and in their own communities.

As a member of Governor Celeste's Home and Community Care Council, it has been my privilege to travel this state and listen to its citizens as they talk about their needs for long

term care. We know in Ohio that our system is fragmented and confusing to those needing such care. It seems every program has a reason or eligibility criteria to say to the consumer: "You don't qualify," followed by a referral to yet another agency. We know in Ohio there is a strong institutional bias in favor of nursing home care in our current system; out of every dollar spent on long term care, 96 cents is spent for nursing home care and only 4 cents is spent for community-based care. We know in Ohio that we are currently underfunding community-based long term care; Ohio ranks 47th in the nation in state dollars spent on community-based care.

We also know, based on experience with the PASSPORT program, that Black elderly are far more likely to utilize community-based long term care services than institutional services. Community-based long term care services enhance the value of the family unit rather than disrupting that unit as the elderly family member is forced to enter a nursing home because community services are nonexistent.

II. IN THE DEBATE OVER THE MEDICARE CATASTROPHIC COVERAGE ACT WE MUST NOT LOSE SIGHT OF THOSE BENEFITS THAT WILL MOST AID THE BLACK ELDERLY.

Recently there has been much controversy over the Medicare Catastrophic Coverage Act (MCCA) of 1988. Most of the debate has focused on the premium surtax and the extent to which the average older person will ever benefit from the Act's provisions

since the Act largely ignores long term care concerns. The debate over MCCA is particularly critical for older Blacks because they are far more likely to depend solely on Medicare for their health coverage than older whites. Nationally, 32% of older Blacks live in poverty. On the average, they have less personal post-retirement income and are more dependent on Social Security benefits for the majority of their income. Thus they are less able to supplement Medicare with additional private resources. For these reasons, it is important to highlight two little-known provisions of MCCA and to urge you to leave these important benefits intact if revisions are made to MCCA.

A. Qualified Medicare Beneficiaries.

MCCA provides Medicaid benefits to certain individuals whose income, while too high to qualify them for the traditional Medicaid program, is below the poverty level. A Qualified Medicare Beneficiary has deductibles and co-insurance charges under Medicare paid by the Medicaid program. This new benefit is particularly important to older Blacks who, as noted above, are less likely to have the economic means to supplement their Medicare benefits with private Medigap insurance coverage.

B. Spousal Impoverishment.

MCCA also seeks, for the first time, to protect the community spouse of a nursing home resident from impoverishment. The Medicaid "spend down" phenomena requires a husband and wife often to spend the savings of a lifetime before Medicaid will pay for costly nursing home coverage. This "spend

down" is accomplished in an average of six months after one spouse enters the nursing home. The spouse residing in the community is reduced to poverty. Those most victimized by this inequity in our current system are black women who have little or no entitlement to Social Security of their own.

MCCA seeks to protect these community spouses in two ways. First, it allows the community spouse whose income is less than 122% of the poverty level a contribution from the institutionalized spouse's income each month. Secondly, it allows the community spouse to keep half of the couple's joint assets up to a maximum of $60,000. More importantly for those of limited assets, it provides that the community spouse be allowed to keep at least $12,000 in assets.

When these new provisions are in place, they will serve as a partial answer to the cycle of poverty caused by the entry of one spouse into a nursing home.

C. The Federal government should increase long term care benefits.

The real problem is that MCCA does not address the long term care needs of older Americans. Your late colleague, Senator Pepper, recognized this more than any other individual. With his passing, I urge you not to lose sight of the laudable goal for which he strived these last few years. He knew that older persons were in greatest need of protection from the devastating effects of long term illness. He sought new expansions in community-based long term care benefits in federal

programs. Perhaps the most fitting tribute that you could give Senator Pepper would be to realize his vision of a long term care system that provides care to elderly persons in their own homes.

I thank you for your kind attention to these remarks and I would be pleased to answer any questions you may have.

Ms. OAKAR. Thank you very, very much, Roland.

And our last but certainly important witness is Larke Recchie, who is Director of our Central Ohio Area Agency on Aging. We are happy to have you here. I am proud of the Ohio thrust, even though it is not perfect, you know, we at least have some things here that are unfortunately not seen in some of the other States, although New York is very progressing, and I am not sure about Maryland, I know a little bit about Maryland in terms of what they have done in breast cancer and things of that nature. But we are happy to have you here, Larke.

STATEMENT OF LARKE U. RECCHIE, DIRECTOR, CENTRAL OHIO AREA AGENCY ON AGING

Ms. RECCHIE. Thank you, Congresswoman Oakar. I will be brief. One of the disadvantages of being last on the panel is that I have heard everything I was going to say said much more eloquently than I was going to say it, so I will spare you and be brief here.

I am the Director of the Central Ohio Area Agency on Aging, and that is the area agency which covers Franklin County and the seven surrounding counties of Columbus. In addition to the planning and administrative functions of the Older American Act funds, our office administers the State PASSPORT program in three of our counties; Franklin, Madison and Union. PASSPORT is a Medicaid waiver program for preadmission screening for nursing home placement and a home care program for Medicaid eligible clients considering nursing homes and with a minimum of ICF level of care determination.

Health care problems of the Black elderly are a special consideration for the area agency in designing and funding in-home and community-based long-term care services in our area. Three phenomena—the increase in life expectancy, the lower incomes of older Blacks and the higher incidents of illness and disability—point to the greater need for special programming for better health care among Black elderly.

Private health care options are prohibitive for the many low-income Black elderly. Medicaid dollars predominantly fund nursing home care and as it has been pointed out, Black elderly are less likely to access this institutional care. Because of this gap in health care services, our agency primarily funds in-home and community-based long-term care services.

The Black elderly represent 11 percent of the elderly in Franklin County. Black elderly compose over 25 percent of those receiving congregate and home-delivered meals through our Title 3C funds, and approximately 30 percent of our PASSPORT clients are Black. These figures point to the greater need, but these services are not adequate in addressing the very great need for these community-based services. Even though access to these in-home and community-based services is greater than institutional access, more effort is needed to make services more readily available to the Black elderly. We need more funding for the kind of creative outreach and the work that is done, for instance, through the Ohio Commission on Minority Health, to make progress toward reaching these very hard to reach, low-income Black elderly.

Another recommendation would be to have a single point of entry for community-based services to aid readily gaining access to the service. A single point of entry would mean that people would be less likely to fall through the cracks.

More funding for a comprehensive, well-coordinated in-home community-based long-term care service which allows for private pay would also help ensure that the "near poor" would not fall into the very poor, very old quite so quickly and easily as they can now without those options available to them.

Other recommendations that we would make are to promote the cultural sensitivity among service providers. It could be very simple and I think that Ms. Boyce pointed this out very well. Our meal provider here in Franklin County, LifeCare Alliance, has made great efforts to be more culturally sensitive and to make the home-delivered and congregate meals more appealing to minority clients as well.

In addition, in the nursing clinics there should be an increased awareness of the special health concerns; for instance, the higher incidence of hypertension and also the effects of poverty on health status in later years.

Not only is sensitivity needed among all the service providers, but I think we also need to search out minority providers. Locally we have the COMOCO program which is headed by Conrad Woody who was one of the cochairs of this National Caucus and Center for Black Aged annual conference, and he does a fine job with limited funding in outreach and supportive services. We have also found through our PASSPORT program with a minority adult day care provider that our minority clients find a greater sensitivity. I think it is more appealing to our minority clients to participate in that adult day-care center.

Other recommendations which I think are a mirror of some of the other recommendations made here are to expand the preventive health education, on a wide variety of issues, but particularly including nutrition. Increase the training and funding for minorities to work in health professions. Minority health professionals bring with them academic knowledge as well as cultural sensitivity to the clients. Large numbers of minority professionals would also serve as role models for younger people to enter health-related professions. More research on health of minority elderly. Research data concerning specific characteristics of health in minorities is scarce, more research is needed. It is also important that when community needs assessments are done, they accurately reflect the numbers and proportions of minorities in the aged population.

Thank you very much for your attention and I also will welcome any questions.

[The prepared statement of Ms. Recchie follows:]

TESTIMONY FOR
U.S. HOUSE COMMITTEE ON AGING
HEALTH CARE PROBLEMS OF THE BLACK ELDERLY
CONGRESSWOMAN MARY ROSE OAKAR
JUNE 14, 1989

Introduction

When discussing an issue such as the health status of the black aged, it is important to note that many of the problems that this specific population encounters are not necessarily different from other members of society. But still, unique circumstances and socio-economic factors affecting black elderly in the United States call for special policy concerns.

What this testimony hopes to convey is, first, demographic and economic trends that have significant bearings on health planning and service provision for the black aged. Secondly, health statistics that indicate the health status of the black aged give an idea of preventative measures and steps to be taken to improve access to services. Finally, some recommendations to improve health and access to affordable care will be presented.

Relevant Statistics

In 1984, over 91 percent of the older population of the United Sates was white, eight percent were black and one percent were other minorities. By the year 2050, the percent of minority elderly age 65 and older is expected to increase to 19 percent (Aging America: Trends and Projections, 1985-1986 edition, p.17).

Also, life expectancy has increased dramatically. The greatest gains occurred during the first half of the century, largely due to reductions in deaths due to infectious diseases. Although in the early part of the century increases in life expectancy were due to decreases in deaths of infants and children, most of the increase in life expectancy since 1970 has been due to decreased mortality among the middle aged and elderly population (Aging America 1985-1986 edition, p.22).

In 1940, life expectancy at birth for whites was 11 years longer than for blacks. In 1983, the difference was 5.6 years. And, the largest gain in life expectancy has been for black females, whose life expectancy has increased 5.5 years from 1970 - 1983. These statistics show that the gap between black and white is narrowing and data indicate that after age 80 life expectancy is actually higher for blacks than for whites (Aging America, 1985-1986, p.24).

Mortality rates, the frequency of deaths in the population, not only have major implications for the numbers and proportion of elderly in the future American population, but they also affect the need for health and social services among the older population. A decrease in the mortality rate does not necessarily mean that those living longer are experiencing good health. Actually, increases in life expectancy may mean that individuals will live more years in poor health.

Robert Atchley states in Social Forces in Later Life (1985 edition, p.279) that there is no support for the notion that older blacks suffer higher mortality rates than older whites over the age of 65. But, "older blacks do have a higher incidence of illness and disability."

Three phenomena, the increase in life expectancy, the lower income of older blacks and the incidence of chronic disease, combined, cause special concerns about the health status of this population.

Economic Factors

When looking at the economic status of older blacks, one finds that minority elderly have incomes substantially lower than their white counterparts. In 1984, the median income of white men age 65 and older was almost twice that of elderly black men (Aging American, 1985 edition, p. 51).

Among those aged 65 - 69, white males had a median income of $12,749 compared to a median income of $7,545 for black men. The median income for white women age 65-69 in 1984 was $6,527 compared to $4,446 for black women. And, in 1984, 56.6 percent, almost three out of five elderly black women, living alone had an income below the poverty level.

THese statistics on the poverty level do not include the 'hidden poor' which may include elderly people with incomes below the poverty level who are living with others, or those Medicaid patients who are in institutions.

Income considerations have significant bearings on health care of the individual. Even with the substantial contribution of public funds, the elderly bear a considerable financial burden for heatlh care out of their own pockets. Direct out of pocket health costs for the elderly averaged 15 percent of their income in 1984. This is the same as before Medicare and Medicaid were enacted in 1965. According to the Health Care Financing Administration, direct out-of-pocket health care expenses for the elderly averaged $1,059 per person in 1984. This includes premium payments for Medicare Part B and private heath insurance. Most expenses incurred are for nursing home care, physician visits and services, and health aids not covered by Medicare, Medicaid, or private insurance (Aging America, 1985 edition, p.51).

Health Status

Just what the health condition of the black elderly population is will have significance to policy and programming for better health care.

Nationally, older blacks are more likely than whites to suffer from hypertension but were like whites with respect to prevalence of heart disease, cancer, and strokes, the main causes of death among older people. However, about 25 percent of older blacks had serious physical limitations of mobility or activity, compared to 14 percent of older whites.

State of Ohio

In 1987, the Final Report of the Governor's Task Force on Black and Minority Health indicated similar findings. In regard to infant mortality, infant diseases per 1,000 were 9.2 for whites and 17.6 for blacks. Lower birth weight and prematurity are major contributing factors to a high infant mortality rate. The report also stated that cancer is a high incidence disease in the black community with poor survival rates, partially due to late intervention. Diabetes is the sixth leading cause of death for Ohio's minority population, with only a 1.3% disparity with whites. The significance of diabetes as a health problem is increased because it is a risk factor for other diseases. Non-insulin dependent diabetes mellitus is the form of the disease contributing to excess mortality and morbidity and obesity in minority women contributes to the prevalence of non-insulin dependent diabetes.

Cardiovascular diseases are the leading cause of death in Ohio regardless of race or ethnicity. Hypertension constitutes the most significant risk factor, leading to strokes, heart attacks and kidney disease. An estimated 284,000 black Ohioans between 18-74 are hypertensive. They represent 28 percent of the black population. The black males in the young-middle age groups have the worst form of the disease.

Franklin County, Ohio

Locally, in Franklin County, Ohio, the Metropolitan Human Services Commission reports, in a draft, the following statistics which mirror national and state data.

The Commission found that populations at risk of needing health care services are: blacks and other minorities; those with low incomes; indigent persons; persons with inadequate health insurance coverage, the uneducated; those who do not practice preventive health; and the elderly.

Blacks comprise approximately 15 percent of the Franklin County population, or about 136,000 people. And studies indicate that:

1) Infant mortality rates for blacks are about double those of whites.
2) Black males under the age of 45 are ten times more likely to die from hypertension than white males.
3) The prevalence of diabetes is 33 percent higher among blacks than whites.

Again, low incomes and low levels of education were found to be highly correlated with poor health and disease. Approximately 132,500 individuals in Franklin County, 25 years of age or older, did not have a high school education in 1980 (28,000 had less than eight years of education). The Columbus Literacy Council estimates that 90,000 individuals are functionally illiterate.

Also, the 1988 Needs Assessment and Survey of Columbus Area Women: Beyond Ozzie and Harriet found that the most immediate concerns of low income women regarding health care services were the cost of health care and treatment for specific conditions. Medicare and Medicaid were used by 17.6 percent of the women in the study, but were found to be inadequate in meeting the needs of older and poor women. High income women were more concerned with prevention and were more likely to list diet and excercise as major health concerns. They were also more likely to be covered by heath insurance.

Recommendations

I. Alternatives to Institutionalization

Much of this discussion has focused on the high cost of health care in proportion to the income of the black elderly individual. PASSPORT is a name of the community-based long term care program in Ohio. The focus of the program is to make available community-based care to elderly people at risk of institutionalization. It is a Medicaid waiver program that responds to long-term care needs of low income elderly. Recent data (1987) show that nearly 30 percent of the clients served in three counties in Central Ohio are black. This figure substantiates the need for such services among the elderly black population. For, in the three counties served, elderly blacks 65 and over comprise only 5 percent of the 65 and older population. (Based on 1980 census data.)

II. Expand Preventive Health Education

Education reegarding nutrition is vital for everyone, and considering the problems of low birth weight, diabetes, and cardiovascular diseases that are prevalent among blacks, one can see how significant knowledge about nutrition and wise eating habits can aid their overall health.

III. Improving Access to Health Services

The Franklin County data on illiteracy show that illiteracy is prevalent. Therefore, pamphlets, posters and other written forms of publicity will not get the attention of many who need service. Aside from educating illiterate people, two ways to improve their access to service would be to have more direct outreach and community-based programs for health care. Also, community-based services that have a single point of entry aid in readily gaining access to service.

IV. Increase Training and Funding for Minorities to Work in Health Professions

Minority health professionals bring with them academic knowledge as well as cultural sensitivity to their clients. Larger numbers of minority professionals would also serve as role models for younger people to enter health related professions.

V. More Research on Health of Minority Elderly

Research data concerning specific characteristics of health and minorities is scarce. More research in this area is needed. It is also important that when community needs asssessments are done, they accurately reflect the numbers and proportions of minorities in the aged population.

Ms. OAKAR. Thank you very much, Larke, and I do have some questions.

But before I do that, I would like to submit for the record a letter from Congressman Chalmers Wylie, who is one of the Members who represents the fine capitol of our State, Columbus, Ohio. I will not read the letter but it is a lovely letter and he is delighted that you are all here and expressed his regret that he has another commitment, but nonetheless he is sensitive to this hearing.

[The letter of Mr. Wylie follows:]

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Congress of the United States
House of Representatives
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June 24, 1989

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SUBCOMMITTEES:
COMPENSATION, PENSION, AND INSURANCE
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JOINT ECONOMIC

The Honorable Mary Rose Oakar
Chairwoman
Select Committee on Aging's
Hearing on Health Care Problems of the
Black Elderly

Dear Madam Chairwoman:

I am delighted that the Select Committee on Aging has selected Columbus, Ohio, as the site of field hearings on Health Care Problems of the Black Elderly. I regret that a longstanding previous commitment prevents me from being present today, but I would like to share with you the following comments.

Today you will look into many important issues facing our nation's black elderly, including the health promotion and lifestyles, the DRG system, mental health needs, and the impact of the catastrophic health care legislation. But, perhaps one of the most significant health issues is long-term care. Last year's Medicare Catastrophic Coverage Act created the U.S. Bipartisan Commission on Comprehensive Health Care which is responsible for making recommendations to Congress for legislation on how to provide coverage of long-term care costs and to help the estimated 37 million Americans with no health insurance. The Commission, composed of six House members, (including yourself Madam Chairwoman), six Senators and three individuals appointed by the Reagan administration, was created at the behest of our late colleague Claude Pepper, who also chaired that panel until his death.

The Commission's legislative report is due to be submitted to Congress by November 9th of this year and it is expected that legislation will be introduced soon after that date. I am looking forward to receiving the recommendations of the Commission with an eye toward cosponsoring a bill to effectively address the critical problem of long-term care.

Madam Chairwoman, I commend you, the members of the Select Committee on Aging and all of today's participants for these hearings. I know the wealth of expertise and testimony that you will hear today will provide a valuable contribution as Congress works to formulate our nation's health care policy for the black elderly.

Very truly yours,

CHALMERS P. WYLIE
Representative to Congress

CPW:G

Ms. OAKAR. Let me ask you a very naive question because you have already said it, but I think sometimes—I remember some years ago I did a little bill that people thought, you know, it was just a small token, they thought it was just way out there, in which I wanted the people who provided services to have a knowledge of other languages. In my district I had some people who viewed English as almost a foreign language for some of them, and it was true that the food—they hated the food, you know, and they did not know how to—they could not talk to many of the workers and so on. So I guess conversely I would like to ask you why is it important that we focus in on the needs of Black elderly in particular, as opposed, you know, to viewing all elderly within the same framework? Anybody want to take that question on? Some of you have already mentioned some things but I just wanted to sort of zero in because here you have this wonderful meeting of the National Caucus and Center on the Black Aged which I was told all about earlier by one of your members who greeted me—founded in 1970. Obviously there was a need for this, so you felt that there were some things that were left falling through the cracks.

What is significant about our focusing in Congress—we have very few minorities in Congress, as you know—what is the significance of focusing in statewide, nationwide, et cetera on these problems?

Ms. BOYCE. Congresswoman Oakar, my feeling is that because of the way that we plan and implement services in this country, we tend to look at aggregate information which means that because there are more Europeans in this country, or people of European descent—

Ms. OAKAR. I wanted you to know that I consider myself a shirttail cousin being Middle Eastern in ancestry. We are sometimes looked upon a little disparagingly also.

Ms. BOYCE. As we tend to look at this global picture, we do not look at—my feeling has always been that we should plan services based on need, risk and service. And for some people there is less need, less risk and a need for more service, but because we are looking at the umbrella, there have been groups who have a greater need, who have not been addressed equitably in terms of resource allocation in terms of services and in proportion to the need. And that is why I think it is very critical that we separate out some groups and focus on the uniqueness of the problem, the uniqueness of the solution, because we get lost in the shuffle when you look at it as aggregated information.

Ms. OAKAR. Right.

Ms. BOYCE. And it is critical that we not base it specifically on age all the time as opposed to some of the other identifying characteristics.

Dr. MORRISON. I think the other issue is that the minority elderly, Black and Hispanic, are increasing rapidly compared to the white population. We always talk about planning and long range planning, but ignore this demographic trend. We know, for example, that minority communities have more children, which means as they age, they will represent a larger proportion of the population, so if we are serious about long-range planning, these are the future cohorts that we really need to begin to deal with right now.

And I am not always so sure that the needs of the Black elderly are qualitatively different from those of older people, but they certainly are quantitatively different in terms of degree. We really do need a lot more.

Ms. OAKAR. Dr. Randolph.

Dr. RANDOLPH. Yes. My contribution would be that I think the social and historical circumstances of Black elderly are quite different from other ethnic or racial groups, that is, they have been denied access, or not permitted access, to employment whereby they would have more secure financial resources, and this accounts for the high rates of poverty. In addition to that, in terms of what Dr. Morrison just said, the report from Work Force 2000 tells us that the large segment of our population, the work or employment base, will be women and minorities; however, if, as Ms. Boyce has said, these minorities—the working, employable minorities—also are straddled with caring for their elderly or aging parents or grandparents, then this is going to also continue to be a situation that is a family problem as opposed to just an individual problem. And so we need to think about dependent care from that perspective as well.

Ms. OAKAR. Let me acknowledge Mr. Simmons, who is the President of NCBA who did give me that information about the organization. I am delighted, Sam, that you are here. This must be a wonderful activity that you are having in Columbus, I hope you can get to Cleveland the next time.

I wanted to ask a little bit about providers because in our study of the needs of people, I am very concerned about having the types of providers for long-term care. It is interesting, I asked a question—we had a hearing the other morning for our commission and I asked these people that were giving us all this data to define long-term care. I have a long-term care bill and what I mean by that I guess is that you take a person who is disabled or elderly and they enter into a program and you say whatever your need is, we are going to give you that—cover that kind of need. And much of it relates to home care services or can relate to home care services. If you need a free physical, you get that; if you need prescription drugs, you get that; if you need surgery, you will get that; if you need to go into a nursing home and in and out of a nursing home as opposed to sticking in there the rest of your life, you have that service. Well the problem you face with home care—and that is why you cannot divorce health issues from fairness in pay and training and so on, and we tend to do that in this country, is you really—very often families who are usually the caregivers, as I think Cheryl, you mentioned, that very often it is the granddaughter who is the caregiver because the mother is incapacitated or perhaps deceased and so on, it is usually a woman who takes care of the individual as well.

I am wondering what you see as how we can get people to go into these areas of caregiving that are very undervalued, and as a result you cannot get quality people and you cannot get the proper training for the people who might have this desire. For example, homemaking services which are very important. People who provide nurse's aid to the individual are very often minimum wage. We cannot even get a minimum wage bill passed for $4.55 an hour

and that does not even cover—we have to have that vetoed, you know—we cannot even get that and that does not cover any other kind of benefits.

So I am wondering what you would see—how should we address that issue relative to—maybe I should just zero in on the caregivers that deal with home health care. If you had your wish list, what would you say we should do for those providers who come into a person's home, a team of providers, what would you like us to do in terms of whatever package we may come up with?

Dr. MORRISON. I would like to take a stab at that one. In New York, we are currently doing some major research on issues related to recruitment and retention of home care workers. You know, one of the major problems is not only recruiting, but there is a significantly high turnover rate. In New York, we have a 50 percent turnover in the first year among people who are home care aides. And it seems to me that the solutions are not really that difficult, it is a matter of whether you are willing to put resources into them.

If they receive low pay, you increase the pay. If they need better benefits, you provide better benefits such as transportation and child care. You provide paid vacations, adequate health insurance, disability insurance, as you would for any other profession.

When you recruit, I think you have to recruit way down in the age range and look, for example, at kids who are in high school who might be interested in going into the health service professions and find ways to support that kind of development for them.

The other thing that is important is the nature of industry regulations. Certainly I know that we have in New York problems with the way hours are put together for home care workers, it makes it very difficult for them in terms of scheduling and getting what is equivalent to a full time job in terms of hours, particularly if clients are spread over long distances and much of the worker's time is taken up with travel.

The other way that I think you could increase the investment—and I mentioned this in my testimony—is to encourage women who have had experience in providing home care services to own, manage and operate their own agencies. I think they manage and operate their own agencies drawing on their hands-on experience. This is a natural for minority and businesswomen enterprises, to develop these kinds of services. The demand and the market is certainly there. And I think it creates a different kind of investment with some ownership and some entrepreneurial spirit in it.

Ms. OAKAR. That is very interesting. You know, sometimes we get into these sort of quasi-rivalry kinds of situations where you have let us say targeted programs for small business or for minorities, and then women want to see targeted programs as well, and so forth. I remember Shirley Chisholm, who was an inspiration to me when I served with her in my early years in Congress, saying that women in all minorities ought to join hands on these issues and not let people separate out, you know, in an effort to do those kinds of things.

I recall a Black woman organization, when I was doing a piece of legislation, related to pay equity, fairness in pay, a little study that some people thought was just disgraceful—I thought it was sort of

obvious, you know, that we needed to implement some changes in the way we value people's jobs. But I remember the Black women saying, "you know, Mary Rose, what you ought to be doing is not just have it related to women, undervalued jobs for women, but undervalued jobs for women and minorities". And the fact of it is, that is what we have tried to do and they are part and parcel, very often similar, you know, in terms of the undervaluing and so on.

But many of you were talking also about providing education for other providers besides the sort of homemaker services and so on. You were talking about more doctors, more licensed professionals, et cetera, psychiatric social workers, et cetera, I think. How does that—I mean should we have—I think this is also inter-related and I want to ask you this question because we have had some decisions lately that have changed the make-up of—should we be targeting that? Should we have affirmative action programs, should we be targeting medical schools to have more training for minorities and so on, or is that sort of passe? It is not easy to get in medical school. I have a young nephew who is white, male and you know, he went through the rigors and now he is a young emergency medical doctor and I do not know how he survived it all because it is so hard for these young kids to work in that profession and work around the clock and all that sort of thing the way they make them do for the cheap labor they provide as residents—but I just wonder, should we be—should Congress, for example, shore up some of those decisions? I mean we recently passed the Civil Rights Restoration Act to restore a right relative to access to education that was diminished by a Supreme Court decision. Should we, you know, hang in there or is that sort of not necessary any more as we have more middle income Blacks, et cetera?

Ms. BOYCE. I do not think we have any choice. The Year 2000 Plan indicates that given the—

Ms. OAKAR. What is that plan? I mean I do not know—

Ms. BOYCE. This is a wonderful plan—this may be my bias, Congresswoman, the plan to me sounds like what is going to happen is the Black and Hispanic population are going to increase so significantly that they are going to have to undergird some of the skilled areas so we had better do a better job of educating or the whole society in this country is going to be in big trouble.

The programs that—

Ms. OAKAR. I would like to have a copy for our record. Okay? So I can study it a little more closely, I would like to know more about it.

Ms. BOYCE. What is happening in Ohio, and I am sure it is happening nationally, is that those programs that were developed to stimulate, economically support training of medical and allied health professionals, by 1990—right now they are at a trickle, by 1990 they will be at a screeching halt. Twenty percent of the minority physicians in Ohio and were doing community serviced in medically underserved areas were here because they had received assistance through Federal programs that no longer exist. The State has labored over how to supplement those kinds of training initiatives. It is a problem that exists in every one of the States and it is not just physicians, it is nurses—there are fewer Black nurses, social work—consistently you look down the level, but if

you look from the other end up as well. One of the programs that we have funded is we took a Tupperware in-party training model for instance and they took the marketing strategy, did in-home parties and the people in that program were people out of the community who received 12 months of a structured program that was designed by doctors, dietitians, the whole 9 yards. Three of those people are now trying to get into undergraduate school. It never occurred to them to come out of the projects and choose health care as a profession.

Ms. OAKAR. Sure.

Ms. BOYCE. I am saying that we need to look at initiatives coming down in terms of the hierarchy of health professions. But ways to take people in the community—the question you asked about in-home training, I would suspect that many people do not seek those kinds of programs because the base pay is so low and they are going to have to give up benefits, so they are taking a net loss, and people in the community know economics well enough to know when they are losing money.

But if there is some continuum that they could build on, if you know that you are going somewhere beyond just that one point—but the data indicates, and talking with and looking at the analyses in every State, that the impact of having people of various racial and ethnic groups trained as providers has such a profound impact on the quality of health status for those populations, that I do not think we can afford not to continue the drive. And I really do not believe that it is something that is going to have enough impact on us, given the mobility between training programs, that unless there is a Federal initiative that it is going to have enough impact.

Ms. OAKAR. And we had some programs.

Ms. BOYCE. We had some. Meharry Medical School, the historically Black colleges, are still turning out a disproportionate number of Black physicians. There has to be some support because those people disperse all over the country. If it is not done as a Federal initiative, it is going to be so piecemeal as not to be effective.

Ms. OAKAR. So it is kind of like an anchor, is it not, for us.

Dr. MORRISON. If you want to argue, I have found that very often the way to sell something to people is on the basis of pure downright self-interest. One of the things that the so-called majority population in this country needs to understand is that when you talk about training minority young people for health professions, you are not just training them for minority elderly. They are going to be the work force of the future. You take a clear example of something like Social Security, which is a transfer program—older people today have income transferred from the working population that exists today. Our Social Security dollars are what support the older people today. Twenty years from now, the support base for Social Security is going to depend on the Black and Hispanic kids who are coming up now, who are my son's age, 19 and 20 years old. We are undereducating them, we are not caring for them, we are allowing that generation to be lost to drugs. Out of purely selfish reasons, if for no other, we ought to protect and nurture and support that generation. That includes preparing them educationally

and socially and emotionally and spiritually for all kinds of tasks that they are going to have to take on in the future. And their destiny is not distinct from ours. We are all wrapped up in this together and somehow that seems to get lost.

Ms. OAKAR. Well you know, there is going to be a trillion dollar surplus, that is probably why they are always trying to get their hands on Social Security, but you are really absolutely correct in terms of the investment, that in people programs and in targeting programs, particularly for our youth, that I think is so important.

I wanted to ask just one or two last questions here. To Dr. Randolph or whomever would like to answer it, I wonder if you could briefly talk a little bit about need for mental health programs as it relates to the treatment of our older Americans, since I think that is such an unfortunate area of neglect, it seems to me.

And I was struck by somebody's comment that in terms of community based mental health programs, minorities do not take advantage of the existing programs to the degree that whites would and so forth.

Dr. RANDOLPH. Yes. I am the National President-elect of the Association of Black Psychologists and in that regard one of the programs that I would like to see our association take on in an advocacy role in trying to promote more of this mental health service, but also something along the lines of, for instance—and this is probably a more idealistic approach—a tax credit for child care. Why could you not have a tax credit for mental health care? If you have something like a food stamp, why could you not have something like a mental health stamp?

Ms. OAKAR. Sure.

Dr. RANDOLPH. Even at the rate of reimbursement, which would be pretty much diminished, you still would be putting people in contact with the system. The same applies for other kinds of health care. We know that prenatal care reduces infant mortality; however, for most African-Americans we know that the problem is making the initial contact with the system. So people have tried approaches of having church-based services and all of these kinds of approaches; the barbershop approach has also been tried in the mental health community. Well all of those take resources even though we contribute a lot of our time as professionals. April is called Black Mental Health Month by our association and each of our 29 chapters tries to do a lot within that small frame with our own resources, but now we need to do a much more coordinated effort.

With respect to the elderly, I think a lot of mental health professionals lose sight of the fact that there are also preventable illnesses amongst the elderly; and so while we try to reach down to the younger populations, I think we have to do much more to educate professionals about the fact that alcoholism and abuse of drugs, even prescribed medications, are real problems for the older age group, and get professionals moving into that age group as well.

Ms. OAKAR. There is such a lack of education with respect to prescription drugs. I have had seminars in my own districts where we have had pharmacists and doctors and nurses come and talk to older people about the questions they do not ask their physicians, when perhaps they go to one or more physician for drug—some

kind of a prescription, and the fact that there are so many side effects and that they act on each other and so on, and that you could really get very, very sick from that, if you are intimidated in asking what you are taking and how they work on each other—just simple educational areas is so very, very important.

Also, there is a tremendous bias against licensed professionals outside—and reimbursement—in terms of the way we issue the Medicare reimbursements, it dates back to 1965 where we will only include doctors and hospitals for the most part, as opposed to psychologists and others, nutritionists—someone talked about foods and so on. You know, these are all kinds of questions—I am not personally convinced, you know, that the European plans and the Canadian plans are the best plans. I think we could structure something in prevention and in dealing with the needs—now that we are starting to focus in on this issue of providing access to health care for every American, and inter-related needs, and we really—I think your testimony, all the material that you all are going to give me, and the PASSPORT program that is a real role-model program for the country in many ways, I think this could be very, very helpful. I have been on the Aging Committee about 15 years now and, you know, what is amazing to me is that I have always learned a lot by going to these hearings.

So I am delighted to have spent this short time with you and hope to keep in touch with all of you. We have some other questions that we would like to submit to you in writing for our record.

I have to leave because we have—in Cleveland, we are celebrating in my immediate neighborhood the 20th anniversary of the Office of Economic Opportunity, which is called CEO in Cleveland. And that provided, 20 years ago, an outreach program where we could go in—get these people to go into the neighborhoods and find the people. We do not have that kind of funding for those kinds of programs where you have para-professionals and professionals working in that manner any longer to the degree that we once did, you know. And I think there has to be a renaissance in terms of evaluating where we are. I am not sure we want to imitate everything, but you have really pointed out such obvious information and yet it is the kind of information that is not talked about a lot.

So I am delighted to have had the pleasure of having you as witnesses and honored to chair this meeting. I want to thank Diana and all of you for your kind attendance this morning.

The hearing is adjourned.

[Whereupon, at 10:35 a.m., the hearing was adjourned.]

APPENDIX

APPENDIX 1

CLOSING THE GAP

Health and Minorities in the U.S.

For the past generation the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 80 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the Office of Minority Health Resource Center (OMH-RC), has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority health areas. Each fact sheet describes the extent to which specific minority groups are affected, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information call the OMH-RC, toll-free, at 1-800-444-MHRC.

Can something be done about the health gap between minorities and nonminorities in the U.S.? A special task force says yes.

The United States faces a health gap. Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans have more illness and higher death rates than other groups in the Nation.

For example:

- Blacks have a life expectancy of 69.6 years compared to 75.2 years for nonminorities—a gap of over 5 years.
- Hispanics die from stomach cancer twice as often as nonminorities—a gap of 100 percent.
- American Indians die from injuries almost twice as often as nonminorities—a gap of nearly 100 percent.
- Chinese American women have a much higher rate of pancreatic cancer than nonminorities—a gap of 20 percent.

Statistics like these, which were compiled in 1984 by the Task Force on Black and Minority Health of the U.S. Department of Health and Human Services, give the Nation its first comprehensive look at a longstanding problem: the disparity in health status between minorities—Blacks, Hispanics, Asian/Pacific Islanders, and Native Americans—and nonminorities. The Task Force report also examines what Americans can do to close the gap between minorities and nonminorities.

IMPROVING THE ODDS

The odds that a black baby will die early in life are greater than those for a nonminority. But researchers have found that the odds can be improved by developing certain habits. To put it in scientific terms, certain risk factors are modifiable.

Here are the modifiable risk factors for the major causes of excess deaths among minorities.

Cancer	Tobacco, diet, alcohol
Diabetes	Obesity
Heart Disease Stroke	High blood pressure, diet, lack of exercise, obesity, tobacco
Infant Mortality	Tobacco, alcohol,late or no prenatal care, adolescent pregnancy, diet
Homicide Suicide	Alcohol, drugs, poor conflict resolution skills
Chemical Dependency	Alcohol, drug abuse, smoking
Unintentional Injury	Alcohol, drugs, environmental hazards

Many Federal, State, and local programs are in place to help you reduce these risk factors. For more information including details on possible grant opportunities, contact the Office of Minority Health Resource Center at 1-800-444-6472 or write to the OMH-RC, P.O. Box 37337, Washington, DC 20013-7337.

The Problem:

Wide Health Disparities Continue

All people in the United States, regardless of race or ethnic background, are healthier now than in 1900. Thanks to the strides made in the medical sciences, life expectancy is higher,and the rate of infectious disease is lower.

The problem is that a gap still exists between minorities and nonminorities, just as it did at the turn of the century. In 1900, for example, more black infants died than white infants, and the gap remains—even though infant mortality rates have declined for both groups.

The gap is most dramatic when measured in "excess deaths": deaths that would not have occurred if minorities had the same age and sex-specific death rate as the nonminority population. More than 40 percent of all minority deaths between 1979 and 1981—60,000 deaths per year—were excess deaths.

What caused the excess deaths? The Task Force discovered that over 80 percent fell into six categories:

Heart disease/stroke . . 18,181 excess deaths
Homicide/accidents . . 10,909 excess deaths
Cancer . . . . . 8,116 excess deaths
Infant deaths . . . . . 6,179 excess deaths
Chemical dependency . 3,164 excess deaths
Diabetes . . . . . 1,660 excess deaths

The good news is that most of these causes of death have modifiable risk factors and are therefore potentially preventable.

The Mission:

Task Force Advises Program for Minority Health

At the end of its year-long study, the Task Force made recommendations that are expected to have a "direct and timely impact on the problems of minority health." The U.S. Department of Health and Human Services (DHHS) should, said the Task Force, 1) launch an outreach campaign to get health information and education materials and program strategies to minorities; 2) ensure that its materials, programs, and technical assistance for patient education are culturally sensitive; 3) develop innovative models for health services delivery and financing that are flexible, accessible, efficient, and culturally acceptable to minorities; 4) work with groups both inside and outside the Federal government to improve the availability and accessibility of health professionals to minority communities; 5) work with State and community groups to develop programs; 6) improve and fully use available sources of data; and 7) adopt and foster a research agenda.

The Strategy:

OMH Implements Task Force Recommendations

Central to plans for closing the gap is the Office of Minority Health (OMH). The OMH, established in 1985, serves as the focal point for the implementation of the recommendations and findings of the Task Force. It is coordinating a long range strategy that involves other government agencies, as well as State, local and private groups. Major activities include conferences, grants for innovative community health strategies developed by minority coalitions, and research on risk factors affecting minority health.

The OMH has established small working groups for each of nine issues. Six groups are addressing the major risk areas for minorities:

- infant mortality
- diabetes
- substance abuse
- cancer
- homicide, suicide, and accidents
- heart disease and stroke

Meanwhile, three other working groups are considering issues that cut across all risk areas and groups:

- health professions development and training
- access to, delivery, and financing of health care
- statistics/data.

These groups will set minority health objectives for the year 2000, create an annual minority health plan for DHHS, monitor progress, and perform an annual review of accomplishments. In addition, they are reviewing current programs within DHHS and recommending changes.

OMH Grants Support Health Promotion Projects

The OMH, through its Minority Community Health Coalition Demonstration Grants, has provided support to twelve community-based projects designed with unique approaches in addressing the reduction of risk factors in minority populations.

These projects have enlisted local health professionals, civic leaders, church groups, school representatives, lay workers, and neighborhood support groups to work together in conducting risk factor reduction efforts among their respective minority communities.

In coming years OMH expects to provide support for additional coalition demonstration grants, as well as establishing an AIDS Grants Program, to develop coalitions that will address the problem of AIDS among Blacks and Hispanics in the U.S.

OMH also collaborates with government and private groups in supporting conferences, meetings, and workshops on minority health-related issues. For example, "The Conference for States and Locales: Developing Minority Health Strategies" was sponsored by OMH in September of 1987. In June of 1988, OMH will cooperate with the Minority Outreach Initiative of the American Lung Association in presenting a conference titled: "Challenge: The Impact of Race, Sex, and Economics on Risk, Prevention and Control of Lung Disease."

OMH Establishes Minority Health Resource Center

The OMH is getting assistance and information to the people who need it through the Office of Minority Health Resource Center (OMH-RC). The OMH-RC was established by OMH in October 1987. The Resource Center maintains information on minority health-related resources available at the Federal, State, and local levels. In addition to serving as a central source of minority health information, the OMH-RC works with the Office of Minority Health in identifying gaps and in stimulating the development of resources where none currently exist.

OMH-RC staff are available to answer mail and telephone (via a toll-free line) requests received from consumers and professionals regarding the six minority health priority areas, their associated risk factors, and the issues that cut across all the areas and groups. Minority Health Information Specialists refer requests to appropriate organizations, locate relevant materials, and identify sources of technical assistance. Bilingual staff are available to assist Spanish-speaking requestors.

A unique feature of the Resource Center is its Resource Persons Network, which links professionals knowledgeable about minority health, who can provide technical assistance, with minority-based organizations, voluntary groups and individuals who want to become more active in health, but lack the technical knowledge to do so. To increase awareness of the health disparity between minorities and nonminorities, the OMH-RC will prepare Fact Sheets on each of the minority health priority areas. These Fact Sheets will describe the extent to which specific minority groups are affected, detail avenues for prevention, and offer sources of additional information.

CLOSING THE GAP

Cancer and Minorities

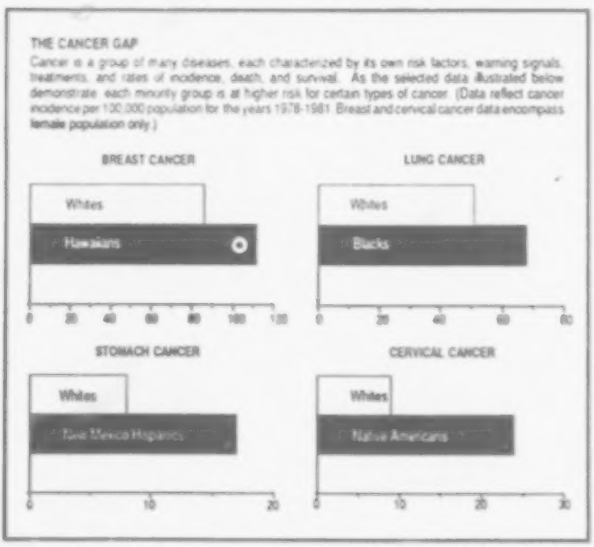
For the past generation, the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 80 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the Office of Minority Health Resource Center (OMH-RC), has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority health areas. This fact sheet describes the extent to which specific minority groups are affected by cancer, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information, call the OMH-RC, toll-free, at 1-800-444-MHRC.

Cancer Hits Some Minorities Hard

Cancer, a leading cause of death among all groups in the United States, hits some minority groups especially hard. A recent report by the Secretary's Task Force on Black and Minority Health found wide gaps in cancer death rates between minorities and non-minorities.

The Task Force looked at cancer rates and risks for Asian, Black, Hispanic, and Native Americans. It found much diversity, wide disparities, and hope for progress through prevention. The information in this fact sheet comes from the Task Force report and reflects the data available in the early 1980s. Data were most plentiful for Blacks. Much less information is available for other groups; much more research is needed.

INSIDE:
BLACKS, HISPANICS, AND NATIVE AMERICANS
The Task Force examined data on:
• Hispanics, including Puerto Ricans and Hispanics in New Mexico & San Francisco
• American Indians
• Alaska Natives
• Black Americans
See page 2


THE CANCER GAP
Cancer is a group of many diseases, each characterized by its own risk factors, warning signals, treatments, and rates of incidence, death, and survival. As the selected data illustrated below demonstrate, each minority group is at higher risk for certain types of cancer. (Data reflect cancer incidence per 100,000 population for the years 1978-1981. Breast and cervical cancer data encompass female population only.)
BREAST CANCER
Whites
Hawaiians
0 20 40 60 80 100 120
LUNG CANCER
Whites
Blacks
0 20 40 60 80
STOMACH CANCER
Whites
New Mexico Hispanics
0 10 20
CERVICAL CANCER
Whites
Native Americans
0 10 20 30

Asians & Pacific Islanders

Cancers of Cervix, Stomach, Esophagus Run High for Some

Cancer rates are rising for Chinese men and women and Japanese men in the United States, reported the Task Force. But Asians and Pacific Islanders, who come from many different countries and cultures, have varying cancer rates. For example:

- Japanese living in the United States have a higher incidence of stomach cancer, and Japanese men have a higher incidence of esophageal cancer than non-minorities. Diet may be a factor in both cases. Studies show that as Japanese people adopt a Western diet, the incidence of stomach cancer falls.
- Chinese in the United States have a high incidence of cervical cancer, multiple myeloma, and esophageal, pancreatic, and nasopharyngeal cancer. (The last is extremely rare.)
- Hawaiians have a high incidence of lung cancer and breast cancer.
- Filipinos in the United States have low survival rates for some cancers, especially colon cancer.

Blacks

Lung Cancer Takes High Toll on Black Men; Smoking a Major Risk Factor

Black men are more likely to die from cancer than any other group in the United States. They have a 25 percent higher incidence of cancer than non-minority men, with more cancers of the lung, esophagus, prostate, stomach, and pancreas. For lung cancer, the gap is very wide: incidence is 45 percent higher among Black men than among non-minority men.

Black women have high death rates for cancer of the cervix—2.5 times higher than non-minorities. They are also at high risk for cancer of the uterus. In general, though, cancer incidence for Black women is close to that of non-minority women.

Some risk factors are of special importance:

- **Tobacco.** Smoking is a major cause of lung cancer. Studies also show that smoking and chewing tobacco are risk factors for esophageal and pancreatic cancer. Alcohol combined with tobacco makes the risk even greater.
- **Nutrition.** Diet is thought to be involved 35 percent of cancer deaths. Salted, smoked, and pickled foods, especially those high in nitrates, may be major culprits in stomach cancer, which is high among Blacks. Fatty foods have been implicated in several kinds of cancer, including prostate cancer, which is also particularly high among Blacks. Foods rich in Vitamins A and C may help prevent some cancers.
- **Occupation.** Black cancer rates rose dramatically after 1950. One reason may be that many Blacks moved to factory jobs in the 1940's and began coming into contact with toxic substances, like asbestos, now known to cause cancer. Some studies show a high cancer incidence among minorities in the steel, dye, and rubber industries.

CANCER TERMINOLOGY

This fact sheet uses certain terms frequently, and some need defining. First, cancer is not one, but a group of more than 100 diseases, all characterized by uncontrolled growth and spread of abnormal cells.

Survival in cancer studies often means living more than 5 years from the time cancer is diagnosed; more and more people are surviving cancer, for 5 and more years; see page 3.

A risk factor is anything that influences a person's chances of getting cancer. Some risk factors, such as smoking, can be changed; others, such as age, cannot. Changing or modifying risk factors, when possible, helps prevent cancer.

Recognition of warning signals, self-examinations like those of the breasts and testis, and routine diagnostic tests performed by a physician are all methods of early detection, which help to discover cancer when chances for survival through treatment are high.

Cancer incidence is the number of new cases in a certain time period, such as a year. Mortality refers to death rates.

♀ BREAST CANCER

Minority at highest risk:
Hawaiians

Risk factors:
Over age 50. Personal, family history of breast cancer. Never had children or first child after age 30. Overweight. High fat diet.

Early detection methods:
Breast self-exam (BSE). 90 percent of breast tumors are found by women themselves.
Mammogram: capable of detecting lumps at earliest, most treatable stages before they can be detected through BSE.

Prognosis with early detection:
In the pre-1950s era of five-year survival rates, the five-year survival rate is 85 percent if the cancer is limited to the breast and has not begun spreading from the breast.

Hispanics

Stomach Cancer Poses Special Danger; Cervical Cancer Rates Are Also High

A Hispanic baby born in New Mexico is twice as likely as an Anglo baby to develop stomach cancer when he grows up. For this and some other kinds of cancer, Hispanics face an especially high risk.

Stomach and cervical cancers lead the list. The Task Force looked at cancer statistics for Hispanics in New Mexico, San Francisco, and Puerto Rico—all for whom it had data—and found that these Hispanics had twice the incidence of stomach cancer as non-minorities. Cancer of the cervix also is twice as common among Hispanics in New Mexico and Puerto Rico as among non-minorities. Both kinds of cancer are declining in the United States, but the gap between Hispanics and non-minorities remains.

Prostate cancer is another cause for concern among Hispanics. Among Hispanic men in New Mexico, prostate cancer has increased 40 percent—4 times faster than for Anglos. It is also on the rise in Puerto Rico.

Other cancers that occur more frequently in Hispanic Americans are cancers of the pancreas and esophagus.

Native Americans

Gallbladder, Cervical, and Lung Cancers Run High in Native Peoples

Some Native Americans face a high risk of dying from gallbladder, cervical, and lung cancer. Rates for these and other cancers vary widely among tribes, however. For example:

- Oklahoma Indians, who tend to smoke more, die from lung cancer at a rate double that of Southwest Indians. They also have high mortality rates for colon cancer.
- Southwest Indians have much higher death rates from gallbladder cancer than Oklahoma Indians. The rate in both groups is higher than in non-minorities, although gallbladder cancer is not common in any group in the United States.

Other cancers for which Native Americans are at special risk include cervical cancer among Native American women; liver cancer in Alaskan Natives; and bronchogenic carcinoma, a cancer of the respiratory system, in Navajos who work in uranium mines.

STOMACH CANCER

Minorities at highest risk:
Hawaiians, Japanese, Native Americans, Hispanics, Blacks, Chinese

Risk factors:
Anemia. Evidence points to diets high in fats and starches and low in fresh fruits and vegetables.

Early detection methods:
Nausea, heartburn, and digestive discomfort are often the earliest signs of stomach cancer. Though these conditions may be symptoms of everyday indigestion, a visit to the doctor is strongly recommended when symptoms persist for more than 2 weeks. By the time other warning signs appear—blood in the stool, vomiting, weight loss—the cancer has likely spread and chances for survival have lowered.

Prognosis with early detection:
Early percent survive when cancer is localized at time of surgery.

CLOSING THE GAP
Office of Minority Health Resource Center

A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-6MHRC, toll free.

Improving the Odds: Risk Reduction and Early Detection Can Save Lives

Cancer can be prevented in many cases. Here's how:

- **Quit smoking to help prevent lung, esophageal, laryngeal, oral, bladder, pancreatic, kidney, and cervical cancers. Tobacco is responsible for 30 percent of all cancer deaths and nearly 90 percent of all lung cancer deaths.**
- **Eat wisely. Diet is thought to be involved in 35 percent of cancer deaths. Studies suggest that people can reduce risk by eating fewer smoked and pickled foods, which are high in nitrates, fewer salty foods, and more fruits and vegetables. Foods low in fat and those high in fiber, such as beans, whole grains, and fruits, may help prevent colon and breast cancer.**
- **Have regular Pap smears. The Pap smear is a simple, quick, and painless test that detects cancer of the cervix; this is one cancer that can be cured easily if caught early.**
- **Have mammograms and other tests. Mammography and examinations can detect breast cancer early. Ask at a clinic or doctor's office about how often you should have these as well as routine tests for colon, rectal, and other cancers.**

Crosscutting Issues

Minority Survival Rates Are Lower

Cancer survival rates are higher today than ever before, due to earlier diagnosis and better treatments. Almost half of all cancer patients now survive 5 years or more.

But survival rates reveal another health gap. For example, only 38 percent of Blacks with cancer survive 5 years after diagnosis, compared to 50 percent of non-minorities. For American Indians, overall cancer survival rates are also low—14 percent lower than non-minorities for men and 16 percent lower for women.

How can more people survive cancer? One way is to find it early. Pap smears, for example, can detect cervical cancer, and doctors can cure it once it is found. Breast examinations and mammograms can detect breast cancer, which also can be cured.

Tied to survival rates is the issue of socioeconomic status. The Task Force found that poorer people are less likely to survive cancer, regardless of ethnic group. Because low-income people often have poor access to medical care, their cancers are not detected until it is too late. The Task Force recommended better health services for minorities.

CERVICAL CANCER

Minorities at highest risk:
Native Americans, Blacks, Hispanics, Hawaiians, Chinese

Risk factors:
Early age at first intercourse, multiple sex partners, history of genital herpes.

Early detection methods:
Regular Pap tests are 95 to 100 percent reliable in detecting early cervical cancer.

Prognosis with early detection:
Eighty to ninety percent of those diagnosed with early cervical cancer survive. When abnormal cells are detected at the precancerous stage, the cure rate is virtually 100 percent.

Cancer Awareness Aids Prevention

How much do people really know about cancer? Some surveys suggest that minorities know less about it than non-minorities.

One study, for instance, showed that Blacks were less likely than Whites to believe that early detection makes a difference. Another found that a quarter of Hispanic women nationwide had never heard of breast self-examination.

The Task Force recommended culturally sensitive health education for minority groups. It suggested, for example, that cancer screening be promoted through clubs and churches and that a "peer corps" of high school seniors be encouraged to lead anti-smoking efforts.

LUNG CANCER

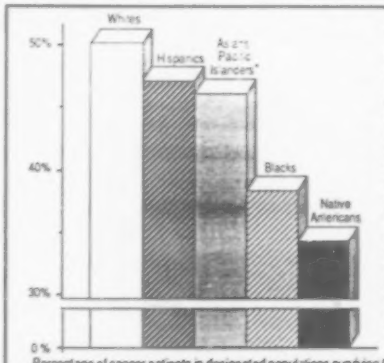
Minorities at highest risk:
Blacks, Hawaiians, Oklahoma Indians

Risk factors:
Cigarette smoking, especially over a period of 20 years or more. Exposure to such industrial substances as asbestos, coal tar, uranium, particularly in combination with smoking.

Early detection methods:
Though doctors are continuing to develop new diagnostic procedures, lung cancer is very difficult to detect in its earliest stages.

Prognosis with early detection:
Only one-fifth of lung cancer cases are caught at the localized stage, and even among those the survival rate is only 39 percent.

Chances for surviving lung cancer once it develops are poor, but the prospects for avoiding it are good since at least 80 percent of lung cancer cases are due to smoking, a risk which can be eliminated by quitting or never taking up the habit.



Percentage of cancer patients in designated populations surviving 5 years beyond diagnosis, 1973-81

*Mean average of percentages for Chinese, Filipino, Hawaiian, and Japanese

THE SURVIVAL GAP

Survival rates, the number of cancer patients living 5 or more years beyond diagnosis, differ markedly from one type of cancer to the next. Early diagnosis and effective treatments help to keep survival figures high for breast and prostate cancers, while numbers remain low for cancers of the lung, esophagus, and pancreas.

Within any type of cancer, survival rates also vary widely between populations. As the chart on the left demonstrates, when all cancer cases are considered together, serious gaps are revealed between minority and non-minority populations. (Source: SEER)

A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services. 1-800-[illegible], toll free.

CLOSING THE GAP
Office of Minority Health Resource Center

Gaining Ground: Minorities Are Working To Close the Cancer Gap

Groups throughout the country have started programs to help reduce cancer risks. Listed below are some examples; for further information contact the OMH-RC.

- **Asian Cancer Awareness Project, Boston, Massachusetts:** This program educates Chinese adult workers about the risks of smoking, alcohol abuse, hypertension, and an unhealthy diet. Conducted by the South Cove Community Health Center. Funded by the Office of Minority Health, DHHS.
- **Cincinnati Minority Cancer Education Program, Cincinnati, Ohio:** Innovative approaches include "Cancer Prevention Awareness Sunday," an essay competition among junior and senior high schools students, and literature in barber and beauty shops. Conducted by the Cincinnati Health Department.

PROSTATE CANCER

Minorities at highest risk:
Blacks, Hispanics

Risk factors:
Over 55, Married

Early detection methods:
Physicians can detect almost all cases of prostate cancer by means of a digital rectal exam, a recommended part of regular physical checkups for men over 40. Because the prostate enlargement caused by cancer can lead to various urinary problems, men should see their doctors if they experience frequent, painful, or difficult-to-control urination.

Prognosis with early detection:
Seventy percent survive when cancer is localized at the time of surgery

- **Community Coalition Project to Reduce Cancer, Washington, D.C.:** The Coalition's aim is to reduce cancer incidence and mortality in high-risk Blacks.
- **Hawaii Cancer Communications System, Honolulu, Hawaii:** This program provides comic books for elementary school children on skin cancer and prepares press releases for school newspapers on smokeless tobacco. The "Breast Self-Examination in Hospitals" program of the National Cancer Institute is also being implemented by this project. Conducted by the Cancer Research Center of Hawaii.
- **Mammography Program, Alviso, California:** A mammography program for Mexican American women is provided in cooperation with the American Cancer Society and the Mexican American Community Services Agency. Conducted by the Family Health Foundation.
- **Minority Cancer Control, The SHARE Harlem Health Project Coalition, New York, New York:** This program aims to reduce cancer risks by promoting health among Blacks and Hispanics in Harlem. Conducted by the Memorial Hospital for Cancer and Allied Diseases. Funded by the Office of Minority Health, DHHS.
- **Y-Mo's Chicago Hispanic Community Project, Chicago, Illinois:** Hispanic women are offered an educational program on breast self-examination and cancer. Conducted by the Erie Family Center.

CLOSING THE GAP: Cancer and Minorities is one in a series of publications produced by the Office of Minority Health Resource Center focusing on each of the minority health priority areas. Other titles planned for this series are:

Chemical Dependency and Minorities
Diabetes and Minorities
Heart Disease, Stroke, and Minorities
Homicide, Suicide, Unintentional Injury, and Minorities
Infant Mortality, Low Birthweight, and Minorities

Other OMH-RC activities include a bilingually staffed toll-free number providing minority health information and referrals, a computerized database of materials, organizations, and programs, and a resource persons network of professionals active in the minority health field. For more information about any of these services, please call the Resource Center at 1-800-444-MHRC.

FEDERAL RESOURCES

Call or write the following Federal offices for information on cancer and associated risk factors.

CANCER INFORMATION SERVICE
1-800-4-CANCER (1-800-422-6237)
A service of the National Cancer Institute which answers cancer-related questions from the public and provides professionals and the public with free publications and referrals to community agencies and services.

CANCER PREVENTION AWARENESS PROGRAM
Office of Cancer Communications
National Cancer Institute
Building 31, Room 10A24
Bethesda, MD 20892
(301)496-5583
Develops educational materials on prevention and provides information on resources for program planners.

NATIONAL INSTITUTE ON AGING
Information Office
Federal Building, 6th Floor
9000 Rockville Pike
Bethesda, MD 20892
(301)496-1752
Distributes information for older Americans on many topics, including cancer and smoking. Some materials are available in Chinese.

OFFICE ON SMOKING AND HEALTH
Technical Information Center
Park Building, Room 1-10
5600 Fishers Lane
Rockville, MD 20857
(301)443-1690
Provides information on smoking and its relation to cancer, on research concerning smoking and health, and on smoking cessation.

ODPHP NATIONAL HEALTH INFORMATION CENTER
P.O. Box 1133
Washington, DC 20013-1133
(800)336-4797
(301)565-4167 in MD
Provides referrals to health organizations, including those concerned with minorities.

AND DON'T FORGET...

OFFICE OF MINORITY HEALTH RESOURCE CENTER
P.O. Box 37337
Washington, DC 20013-7337
1-800-444-MHRC (6472)
Answers requests from consumers and professionals on minority health—issues, risk factors, resources, and programs.

CLOSING THE GAP

Diabetes and Minorities

For the past generation the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 60 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the Office of Minority Health Resource Center (OMH-RC), has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority areas. Each fact sheet describes the extent to which specific minority groups are affected, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information call the OMH-RC, toll-free, at 1-800-444-MHRC.

DIABETES: THE GAP IN DEATH RATES

Diabetics are at increased risk for stroke, heart attack, and a variety of other potentially fatal conditions. A contributing factor to 300,000 deaths per year, diabetes has been ranked seventh among leading causes of death in the United States. As serious as the problem is for non-minorities, the diabetes death rate for minorities—as demonstrated in this chart—is even higher.

Age adjusted death rates calculated from underlying-cause of death data, United States, 1980.

Minority Populations Threatened By Diabetes and Its Complications

Diabetes and its complications kill thousands of people each year, and a large share of them are minorities. In fact, diabetes statistics reveal a wide health gap between minorities and non-minorities, according to the Report of the Secretary's Task Force on Black and Minority Health.

The Task Force looked at diabetes rates for Asian and Pacific Islanders, Blacks, Hispanics, and Native Americans. It found much diversity among and within groups, but the overall picture showed unusually high rates of type II diabetes among minorities. The findings, statistics, and studies cited in this fact sheet come from the Task Force Report and reflect the data available in the early 1980s. Data were most plentiful for Blacks. Much less information was available for other groups; much more research is needed.

Asians & Pacific Islanders

High Diabetes Rates Linked to Diet

Diabetes is a "significant problem" among at least four groups of Asians and Pacific Islanders in the United States. Although data are scarce, one study has shown that Filipinos, Japanese, Koreans, and Chinese living in Hawaii have double and triple the diabetes rates of white non-minorities.

Most other studies available to the Task Force concerned the Japanese. Among Japanese men in the United States aged 40 or older, researchers found the diabetes rate to be as high as 10 to 14 percent. Another study suggests that Japanese living in the United States have, as a group, more than twice as much diabetes as Japanese living in Japan. Still another study found that Japanese-Americans who were born in the United States have higher death rates from diabetes than their native-born relatives.

Why the differences? The Task Force noted that Japanese diets in the United States are generally much higher in fat—both animal fat and total fat—than in Japan. Also, Japanese in the United States tend to have a higher proportion of fatty tissue, even though they are not overweight. This suggests that a high-fat western diet could be to blame.

INSIDE: BLACKS, HISPANICS, AND NATIVE AMERICANS

The Task Force also examined data on:
- Hispanics, including Puerto Ricans and Mexican Americans
- American Indians
- Alaska Natives
- Black Americans

See page 2

WHAT IS DIABETES?

Diabetes is really three different diseases, all characterized by glucose intolerance. This is the inability to properly use glucose, a form of sugar, whether eaten or produced by the body after a meal.

The most common kind of diabetes is the one this fact sheet talks about: non-insulin dependent diabetes mellitus (NIDDM) or type II diabetes. NIDDM develops most often in adults over 40, especially those who are obese. People with this type of diabetes manage the disease through diet, weight control, and exercise, often accompanied by oral diabetes medication or insulin.

Insulin dependent diabetes mellitus (IDDM) or type I diabetes is much less common and usually develops in children and young adults. People with IDDM must have regular insulin injections.

Gestational diabetes is a mild form of diabetes that that affects women only during pregnancy. Women who have had this form of diabetes are more likely to develop NIDDM when they are older.

People with diabetes often have unusual thirst, frequent urination, fatigue, or an ill feeling.

Blacks

Rates Highest Among Obese

Diabetes is 33 percent more common among Blacks than among Whites, and the picture is even worse for Black women. Black women have 50 percent more diabetes than White women and face an even greater risk if they are obese.

The complications of diabetes also are more frequent in Blacks. Heart disease, stroke, kidney failure, and blindness—all are more common among Blacks with diabetes than among Whites with diabetes.

Yet another complication involves babies. Infants born to women with diabetes are much more likely to die near the time of birth than others. For the babies of Black women with diabetes, the death rate is three times what it is for babies of White women with diabetes. Good medical care before and during pregnancy can reduce this risk.

Hispanics

Risk is 300 Percent Higher

Hispanics in the United States have three times or 300 percent the risk of developing diabetes as non-Hispanic Whites. As in some other groups, obesity appears to be a factor, although social and economic forces may also play a role.

One study in San Antonio, Texas, showed that women living in poor urban neighborhoods or barrios were four times more likely to have diabetes than Hispanic women living in the suburbs. For barrio men the diabetes rate was twice as high. It is not clear why this is so, but the Task Force noted that obesity is more common in barrios, and that most adults who develop diabetes are obese. Differences in diet, therefore, may play a role.

In another study, researchers discovered that Puerto Rican men living in Puerto Rico were three times more likely to have diabetes if they lived in a city. Those living away from cities had much lower diabetes rates. Some of the difference seemed to be related to obesity, but again, not all the reasons were clear.

The Task Force suggested that various socioeconomic and cultural factors, which in turn are related to various health habits like diet and exercise, may play a role in the development of diabetes.

Native Americans

Disease Has Mushroomed in Last 50 Years

Fifty years ago, diabetes was rare among Native Americans. Now it is so common that in many tribes 20 percent of the people suffer from diabetes. Native Americans are ten times or 1000 percent more likely than Whites to develop this disease.

The sharp rise in diabetes among American Indians and Alaska Natives "can only be termed an epidemic," said the Task Force. In one tribe, the Pima, nearly 50 percent of those over 35 are affected.

A dramatic increase in obesity among Native Americans has accompanied the dramatic increase in diabetes. Photographs of American Indians taken 100 years ago show that most were lean. Now, obesity is common.

Genetic and familial factors may also play a role; that is, some Native American families may be more likely to develop diabetes than others.

The complications of diabetes, especially kidney disease and blindness, are especially severe for Native Americans. American Indians with kidney disease brought on by diabetes more frequently need dialysis than other diabetics; other problems related to diabetes result in more amputations.

Hundreds of Native American tribes live in the United States. The Task Force did not have data on all of them, but it found these tribes in which more than 20 percent of adults have diabetes.

Tribe	Percentage with diabetes *
Pima (Arizona)	49.5
Papago (Arizona)	42.2
San Carlos Apache (Arizona)	24.9
Upland Yuman (Arizona)	37.6
Maricopa (Arizona)	29.8
Cocopah (Arizona)	24.4
Zuni (New Mexico)	24.7
Paiute (Nevada)	25.9
Seminole (Florida)	37.8
Cherokee (North Carolina)	29.0
Cherokee (Oklahoma)	20.2
Pawnee (Oklahoma)	24.6
Alabama-Coushatta (Texas)	22.6
Seneca (New York)	20.9

Numerous other Native Americans, including the Navajo, the Choctaw, the Chickasaw, the Cheyenne-Arapaho, the Kickapoo, the Shawnee, and the Comanche, have rates two, three, and four times higher than those of non-Americans.

Complications of Diabetes: KIDNEY DISEASE

A diabetic's high blood sugar forces the kidneys to filter more blood than actually needed to keep wastes in the blood low. This overwork may lead to a gradual degeneration of the kidneys' vital cleansing system. Known as diabetic nephropathy, this condition develops in 10 percent of those with diabetes.

Over a period of many years, kidney function may diminish as much as 80 percent before the decline reveals itself in symptoms like anemia, nausea, weakness, and high blood pressure. Medical intervention such as dialysis or transplant may be necessary when kidney function declines by 90 percent or more. Even with such treatments available 80,000 kidney disease deaths occur annually in the United States, with 10 percent attributable to diabetes.

CLOSING THE GAP
Office of Minority Health Resource Center

A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-MHRC, toll free.

Complications of Diabetes: BLINDNESS

Diabetes is the leading cause of blindness in people between the ages of 20 and 74, with the highest rates of blindness due to diabetes occurring in non-white, minority populations. The primary vision disorder affecting diabetics is retinopathy, a condition in which enlarged and damaged capillaries lead to swelling and hemorraging within the retina, often impairing the portion of the eye specializing in detail vision. As capillaries become closed off, new blood vessels form, breaking through and leaking into the inner surface of the retina and seriously interfering with vision.

Retinopathy can be detected early, before damage is evident, and a variety of treatments, including laser therapy and surgery can improve vision and slow retinal damage in those with the condition. Nonetheless, 5000 people per year lose their vision as a result of diabetes. It is estimated that with proper care and treatment this figure could be cut in half.

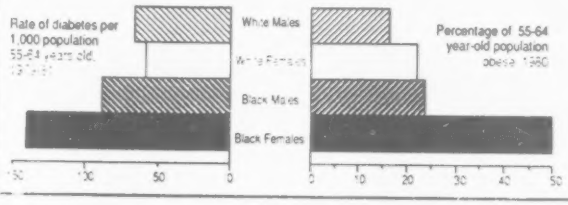
Improving the Odds: Risk Reduction for Diabetes and Its Complications

Here are some ways to reduce the risk of diabetes and its complications:

- **Maintain a desirable weight. Keeping weight at moderate levels can make a big difference in health, and it may prevent diabetes. For people who already have diabetes, losing weight can make it much easier to control.**
- **Become physically active. Exercise not only helps control weight, but also improves glucose tolerance.**
- **Don't smoke. Smoking increases the risk of complications.**
- **Get medical checkups. Thousands of people have diabetes and don't know it. If you have a family history of diabetes, are overweight, and are above the age of 35, you may be part of the diabetes risk group. Clinics, doctors' offices, and screening clinics can test for diabetes.**
- **Follow a doctor's advice. Taking medication and watching your diet can help control diabetes and its complications.**

DIABETES AND OBESITY: THE CORELATION . . .

As this pair of graphs shows, diabetes rates often mirror obesity rates. Though obesity is just one of several major risk factors for the disease, statistics examining a variety of populations reveal a strong corelation between these two health problems. Ninty-nine percent of diabetic Oklahoma Indians examined in one study were fat before the onset of the disease, while Mexican Americans studied in San Antonio, Texas were more than twice as likely develop diabetes if they were overweight.



. . . AND THE CONNECTION

Researchers theorize that obesity contributes to diabetes when fat cells "resist" insulin's ability to regulate blood glucose. The obese body may produce enough insulin, but because fat cells deplete or weaken the receptors which recognize and respond to it, the insulin's effictiveness is reduced.

Obesity seems especially likely to lead to diabetes in those with a family history of the disease. Thus people genetically inclined to develop diabetes can beat the hereditary odds by remaining thin. And among the obese who already show diabetic symptoms, reducing to a normal body weight can dramatically reduce the need for medication and even eliminate the condition altogether. Obesity is the single most controllable risk factor both for diabetes and for many of its complications.

CrosscuttingIssues

Diabetes Control Can Curb Death Rates

With diabetes, it is often the complications that kill. People with diabetes have twice as many heart attacks and about twice as many strokes as other people. Kidney disease, blindness, circulation problems, and birth defects are among its other complications.

The Task Force quoted statistics showing that good management of diabetes could prevent these complications in a large number of cases. For example:

- Controlling high blood pressure in people with diabetes could reduce strokes by 75 to 90 percent, coronary heart disease by 25 to 50 percent, and peripheral vascular disease (circulatory problems) by 30 to 60 percent.
- By quitting smoking, people with diabetes could reduce strokes by 5 percent, coronary heart disease by 10 percent, and peripheral vascular disease by 30 percent.
- Early diagnosis and treatment for proliferative retinopathy, an eye problem caused by diabetes, could reduce severe visual loss by more than 50 percent.
- Good foot care could reduce amputations by more than 50 percent.

Complications of Diabetes: HEART DISEASE

A higher incidence of diabetes in minority populations contributes to the higher death rate from heart failure in the same populations. The leading cause of death among adults in the United States, heart disease is 2 to 4 times more likely to affect diabetics than the general population. Not all the connections are clear, but it is evident that higher incidence among diabetics of such coronary risk factors as hypertension and increased fat and cholesterol in the blood contribute to their chances of developing heart disease.

One-third of all deaths among people with diabetes are attributable to heart disease. Coronary artery disease alone claims 38,000 diabetics annually, and it is estimated that preventive measures could reduce this mortality rate by 45 percent.

Gaining Ground: Minorities Are Working To Close the Diabetes Gap

Groups throughout the country have started programs to help reduce the impact of diabetes. Here are some examples; for more information contact the OMH-RC.

- **El Paso Coalition for Hispanic Health Promotion, El Paso, Texas.** The Coalition is working to reduce the incidence of diabetes through an education program aimed at reducing obesity in the Mexican American community. Conducted by the Paso del Norte Area Health Education Center. Funded by the Office of Minority Health, DHHS.

- **The Reducing Risk for Diabetes Among Mexican Americans Project, Dallas, Texas and Los Angeles, California.** This is an 8-week diet and nutrition training program to reduce the risk of diabetes, through the combined efforts of Hispanic groups working with the American Red Cross, the American Diabetes Association, and other community-based agencies. Sponsored by the National Coalition of Hispanic Health and Human Services Organizations. Funded by the Office of Minority Health, DHHS.

- **California Diabetes Control Program, California.** A set of 12 bilingual (English/Spanish) patient education materials have been developed for Hispanics. All are targeted to persons with limited reading skills and provide information on Mexican foods and their caloric content.

- **Diabetes Care Program, Memphis, Tennessee and Atlanta, Georgia.** Medically indigent Blacks gain continuing access to care through this program, which has developed a prevention-oriented approach, including early detection, patient education, optimal therapy, and continuing follow-up care.

- **Diabetes Programs, Indian Health Service.** Centers of excellence like Claremore, Winnebago, Tuba City, and Albuquerque offer comprehensive, culturally relevant diabetes education and followup. Programs in Zuni, Sacaton, Maine, and Browning promote exercise as a way to help Indians with diabetes lose weight to improve control. School children and family members participate in exercise sessions and community members learn about diabetes.

Complications of Diabetes: AMPUTATIONS

Forty-five percent of amputations not caused by injury occur as a complication of diabetes. Most often these amputations—usually of the foot or lower leg—are necessitated by gangrene or ulceration resulting from peripheral arterial disease. This condition, which is 4 times more common in diabetics than in non-diabetics, involves both hardening of the normally elastic arterial walls and deposit of plaque within the artery. These changes can narrow and eventually block the blood vessel completely, seriously damaging circulation in limbs and extremities, placing them at increased risk for infection. Risk of onset and degeneration from arterial disease can be lowered by quitting smoking, controlling high blood pressure, and maintaining appropriate [illegible] levels. Among diabetics, 45 percent of the 24,000 new cases of peripheral arterial disease per year are estimated to be preventable.

FEDERAL RESOURCES

CDC DIABETES CONTROL PROGRAM
Division of Diabetes Control
Centers for Disease Control
Atlanta, GA 30333
(404)639-1848
Promotes control of diabetes in 29 States and one Territory, many of which target minority populations for special emphasis.

NATIONAL DIABETES INFORMATION CLEARINGHOUSE
Box NDIC
Bethesda, MD 20892
(301)468-2162
Provides consumer and professional information on diabetes and its complications.

NATIONAL INSTITUTE ON AGING
Federal Building, 6th Floor
9000 Rockville Pike
Bethesda, MD 20892
(301)496-1752
Distributes a consumer publication on diabetes in the elderly, which is also available in Chinese.

ODPHP NATIONAL HEALTH INFORMATION CENTER
P.O. Box 1133
Washington, DC 20013-1133
(800)336-4797
(301)565-4167 in MD
Provides referrals to health organizations including those concerned with minorities.

AND DON'T FORGET...

OFFICE OF MINORITY HEALTH RESOURCE CENTER
P.O. Box 37337
Washington, DC 20013-7337
1-800-444-MHRC (6472)
Answers requests from consumers and professionals on minority health, risk factors, resources and programs.

Complications of Diabetes: STROKE

Studies have found that a history of stroke is up to 4 times more common in diabetics than in non-diabetics. In addition, cerebrovascular disease has been found listed on 25 percent of death certificates in which diabetes is the underlying cause of death. Since high blood pressure is a major risk factor for stroke, the correlation between stroke and diabetes may be largely due to the increased prevalence of hypertension in diabetics, almost twice that of the general population. Good control of high blood pressure might prevent up to 85 percent of the 19,000 strokes occuring annually among diabetics.

CLOSING THE GAP: Diabetes and Minorities is one in a series of publications produced by the Office of Minority Health Resource Center focusing on each of the minority health priority areas. Other titles planned for this series are:

Cancer and Minorities
Chemical Dependency and Minorities
Heart Disease, Stroke, and Minorities
Homicide, Suicide, Unintentional Injury, and Minorities
Infant Mortality, Low Birthweight, and Minorities

Other OMH-RC activities include a bilingually staffed toll-free number providing minority health information and referrals, a computerized database of materials, organizations, and programs, and a resource persons network of professionals active in the minority health field. For more information about any of these services, please call the Resource Center at 1-800-444-MHRC.

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CLOSING THE GAP

Chemical Dependency and Minorities

For the past generation the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 80 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the Office of Minority Health Resource Center (OMH-RC), has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority health areas. Each fact sheet describes the extent to which specific minority groups are affected, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information call the OMH-RC, toll-free, at 1-800-444-MHRC.

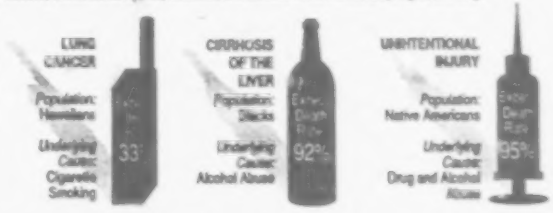
Minorities Often Victims of Alcohol-, Drug-, and Tobacco-Related Deaths

Alcohol is a factor in more than 10 percent of all deaths and 50 percent of all homicides; tobacco in 90 percent of all lung cancer deaths; drugs in 10 percent of all homicides. Amid these statistics, minority groups stand out as frequent victims. Compared to non-minorities, said the Secretary's Task Force on Black and Minority Health, "chemical dependency has had a greater negative impact on the health of minorities."

The Task Force examined chemical dependency among Asians and Pacific Islanders, Blacks, Hispanics, and Native Americans. It found much diversity, wide disparities, and hope for progress through research, prevention, and treatment. The statistics cited in this fact sheet come from the Task Force report and reflect the data available in the early 1980s. Data were most plentiful for Blacks. Much less information was available for other groups; much more research is needed.

CHEMICAL DEPENDENCY: EXCESS MINORITY DEATHS

Alcohol, tobacco, and illicit drug use are factors in about one quarter of U.S. Deaths each year. Data indicate that the portion of minority deaths arising from these causes is even greater than that in the general population. We can gain some insight into the gravity of chemical dependency as a contributing cause of death among minorities by examining the excess incidence and mortality figures for some major causes of death within specific populations. The underlying substance-related cause cannot be implicated in every excess death from these causes. Nonetheless, evidence suggests that curbing the use and abuse of alcohol, drugs, and tobacco could help minorities close the gap in death rates from cirrhosis, heart disease, unintentional injuries, homicide, and cancers of the mouth, esophagus, and lung.



Excess incidence and death rates are the difference between rates actually occurring in the designated populations and those that would have been expected had the group experienced the same age and sex specific rates as the nonminority population, which furnish a baseline of 100 percent.

Asians & Pacific Islanders

Tobacco Linked to High Cancer Risk

Japanese and Chinese people living in the United States face a greater risk than Whites of developing two cancers linked to smoking: cancer of the esophagus and cancer of the pancreas. The Task Force found that the incidence of esophageal cancer is two and a half times higher for Japanese men, 1.8 times higher for Chinese men, and 1.6 times higher for Chinese women than for their White counterparts.

Cancer of the pancreas is 20 percent higher among Chinese women than among White women, and this cancer is increasing in both Chinese men and women. Native Hawaiians have an excess incidence and mortality for lung cancer.

Data are scarce on alcohol and other drug abuse among Asian and Pacific Islanders. A few studies indicate lower rates of alcohol and drug use than in the general population, but others indicate that problems do exist among some groups. Native Hawaiians, for example, report heavier drinking than other groups in Hawaii and appear to be at a greater risk of car accidents that involve alcohol.

Blacks

Smoking Death Rate Runs High

More Blacks than Whites smoke, and more die from lung cancer as a result, reported the Task Force. Both Blacks and Whites are smoking less than they used to, but a gap remains between Black and White men. Among Black and White women, smoking rates are about the same. For all groups in the U.S., smoking is the chief, preventable cause of death.

Patterns of smoking differ. Blacks smoke fewer cigarettes overall than Whites, but smoke more cigarettes high in tar. One survey found that more Blacks than Whites are interested in quitting.

Looking at alcohol related deaths, the Task Force found that the Black death rate from cirrhosis of the liver is double that of Whites. For esophageal cancer, the Black death rate is 10 times higher; smoking and drinking increase the risk of esophageal cancer.

But again, the patterns differ. Up to age 30, Blacks drink less than Whites, while after age 30 they drink more. Blacks at all ages are more likely either to abstain from alcohol or to drink heavily. Social class is a factor. Studies show that Blacks and Whites of similar social classes drink similar amounts of alcohol.

Illicit drugs also play a role in many Black deaths. Between 1982 and 1984, cocaine deaths doubled among Whites but tripled among Blacks. Black drug users are more likely to combine cocaine with alcohol and other drugs and to use intravenous drugs; both practices are especially dangerous. Blacks are three times more likely than Whites to be in treatment for drug-related problems.

Hispanics

Alcohol Use High in Young Men

Hispanic men aged 18 to 29 reported more heavy drinking than Anglos in a national survey and higher rates of alcohol related problems. Other studies confirm this health gap between Hispanic and Anglo men. Hispanic women, on the other hand, tend to be light drinkers or abstainers.

MISUSE OF PRESCRIPTION DRUGS

Alcohol abuse, illicit drug use, and cigarette smoking are the kinds of chemical dependency addressed by the Task Force. The misuse of prescription drugs, sometimes included in the term 'drug abuse', also causes serious health problems. This was not included in the Report, however, because little information was available on its prevalence or effects among minority groups.

Drug use among Hispanics may also be high. While Anglo deaths from cocaine doubled between 1982 and 1984, they tripled among Hispanics. Hispanics are 2.7 times more likely to be in treatment for drug related problems than non-Hispanic Whites.

Smoking is more common among Hispanic men than women, but among adolescents, both boys and girls are often smokers.

Included in the Task Force Report was a special paper on Hispanic alcohol use which made these three recommendations for prevention and treatment programs. 1) Obtain community input at all stages of planning and implementation, paying special attention to the clergy, general practitioners, and Hispanic organizations. 2) Design programs that respond to specific problems in specific groups. 3) Take cultural norms and attitudes into account; historically, Hispanics and Anglos have had different attitudes toward drinking, and these must be considered in designing an effective program.

Native Americans

Alcohol-Related Death Rate High

American Indians and Alaska Natives die more frequently than non-minorities from suicide, homicide, and unintentional injuries or accidents, most of which are related to alcohol. These causes, along with cirrhosis of the liver and alcoholism, account for more than a third of all Native American deaths.

"Alcohol use varies tremendously from one tribe to the next," said the Task Force, and some tribes have fewer adult drinkers than the general population. But for Native Americans as a whole, death rates from alcohol related causes are more than three times higher than among other groups.

Drug use also appears to be high among Native Americans, who are twice as likely as Whites to be in treatment for drug abuse. In one survey, 58 percent of Native American high school seniors said they had smoked marijuana compared to 50.5 percent of seniors in the National Institute on Drug Abuse's annual survey.

Smoking habits vary widely between tribes, but smoking is more prevalent among the Oklahoma tribes, which also have high rates of lung cancer.

ALCOHOL:
Complications and Consequences

The health effects of alcohol abuse are complex and differ across the various minority populations and even between subgroups of a population. Furthermore, most national studies were designed to obtain baseline data on the general population, so there is very little data specific to minorities.

Cirrhosis of the liver

Cirrhosis, a group of chronic liver diseases in which normal cells are damaged and are replaced by scar tissue, is one of the major health problems associated with alcohol. This process disrupts the liver's many important functions, including maintenance of blood chemistry and detoxification of drugs, poisons, and alcohol.

Cirrhosis kills about 30,000 Americans annually, and alcohol is a major risk factor for these diseases. While cirrhosis mortality rates have declined consistently since 1973, the rate among the non-White population is still double that of the White population. Cirrhosis is the fourth leading cause of death among Native Americans, accounting for 6 percent of the total deaths in this group compared to 1.7 percent for the Nation. Data are scarce for Hispanics and Asians/Pacific Islanders.

Fetal Alcohol Syndrome

Diagnosed in one of every 750 live births, Fetal Alcohol Syndrome (FAS) is another alcohol-related health problem. Proportionately, most FAS cases are found in the high risk groups for alcoholism, including Native Americans, the poor, and children of older mothers. The disease, identified in the early 1970's, is marked by birth defects that can occur among pregnant women who drink heavily. Alcohol passes across the placenta into the fetal bloodstream and reaches the same concentration as that in the mother. The symptoms include brain damage, small size, and facial and bodily abnormalities. Newborns who exhibit only some of these symptoms are said to have Fetal Alcohol Effects (FAE).

Incidence of FAS/FAE varies among Native American tribes, from a rate of 10.3 cases per 1,000 births among Plains Indians to 1.3 per 1,000 among Navajo. Black women also appear to be at risk for FAS/FAE, but Hispanic and Asian American women are less at risk because of lesser alcohol intake. However, there is insufficient data to draw conclusions on risk and incidence rates for these groups.

Accidental and violent death

Alcohol is also a major risk factor for accidental and violent deaths. Most data has been gathered on Native Americans, and the majority of accidental deaths, suicides, and homicides in this group are alcohol-related.

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Improving the Odds: Communities Can Fight Alcohol and Drug Abuse

Minorities are working to reduce the risks through community and parent programs, schools, and clinics. What they have learned so far was reflected in Task Force recommendations. Here are a few of the approaches suggested:

- **Help children and teenagers develop coping skills to delay or prevent smoking, drinking, and use of illicit drugs.**
- **Foster peer-group instruction in schools to strengthen resistance to alcohol, other drugs, and tobacco.**
- **Train health professionals increasingly in the diagnosis, prevention, and treatment of chemical dependency.**
- **Use culturally appropriate strategies. For example, Native American health programs should be planned in conjunction with the traditional medicine men of Native American society.**
- **Increase research on cirrhosis of the liver, alcohol and pregnancy, the epidemiology, etiology, and consequences of chemical dependence among minorities.**

Crosscutting Topics

Cultural Traditions Help in the War on Alcohol, Drugs

Different minority groups have different ways of coping with stress and adversity, noted the Task Force, and "coping patterns may play a crucial role in health outcome. An increasing body of research suggests that the ways an individual copes with stress and the resources available to resolve stressful situations, rather than the stressor itself, play the more important role in health outcome. In some minorities, traditional folk beliefs and culturally specific family patterns may affect their ability to withstand social, economic, and psychological stressors."

In other words, certain cultural traditions may help a person cope with stress that might otherwise be a factor in health problems, including abuse of alcohol and other drugs. For example:

- **Asians and Pacific Islanders often "pride themselves on their independence and self-sufficiency. Consequently, some are particularly reluctant to seek health services, especially for mental illness or for counseling." The Task Force also commented that "the family is very important to many Asians," and that family reliance can strengthen an individual's social support resources, but it "may also pose a barrier to care when it is truly needed."**
- **Blacks traditionally "have placed great importance on kinship and family ties, which often form the basis of a network of mutual support... Also, the church is a powerful source of emotional strength for many Blacks." A hundred years ago, the Task Force noted, Blacks in the United States had lower rates of alcohol use than Whites, a tradition that may be reflected in the large numbers of abstainers among Blacks even today.**
- **Hispanics in the United States have "a very strong family and community orientation." In addition, "the church and parish community are an important focus of family and social life for many Hispanics. In more rural settings, some Hispanics view the community as an extension of the family and feel that it has a protective and healing force that may be used to reinforce an individual's own coping skills."**
- **Native Americans have seen their traditional way of life disrupted, and "a sense of powerlessness and hopelessness has often been observed as a result and may be related to the high incidence of alcohol abuse, suicide, depression, and obesity among this population." But, the report continues, "American Indians...are also observed to draw upon traditional sources of strength to cope with stressors. Traditional strengths include the family, the tribe, and the land itself."**

SMOKING:
Complications and Consequences

Cigarette smoking is a major cause of a large number of diseases, including emphysema (a disease that destroys the lining of lung tissue); cancer of the lung and airways; coronary heart disease (CHD); and arteriosclerotic peripheral vascular disease. Cigarette smoking is also linked to many other cancers and to low birthweight.

Smoking prevalence has decreased in all U.S. population groups in the past two decades; however, lung cancer incidence and mortality rates have increased among both Blacks and Whites. While the estimated mortality rates for 1990 are nearly similar among Black and White females, the age-adjusted estimate for Black males is 11 percentage points higher than that for White males. Blacks also have lower 5-year survival rates than Whites by 2 to 10 percentage points for cancer of the lung and airways.

Smoking also adds to the risk of CHD in both Blacks and Whites. Since hypertension is more prevalent in Blacks than in Whites, the Task Force Report notes that Blacks who smoke and have a history of hypertension are at an increased risk of dying from coronary heart disease.

Lung cancer morbidity and mortality rates are lower for Hispanics than for Anglos and Blacks, and Hispanics also appear to be at lower risk for CHD. However, these findings are several years old and reflect a time period when Hispanics smoked less than Anglos. Current evidence suggests that Hispanic males are now as likely to be smokers as White males.

There are very little data on smoking prevalence and patterns among Native and Asian Americans. While risk of smoking-related diseases appears lower among these groups compared to Blacks and Whites, certain tribal or ethnic subgroups exhibit smoking-related cancer rates equal to or greater than those in Black and White populations.

Gaining Ground: Minorities Are Working to Close Drug and Alcohol Abuse Gaps

Groups throughout the country have started programs to help reduce the risk and harm of chemical dependency. Here are some examples; for more information contact the OMH-RC.

- **ACOA Indian Alcohol Prevention Team, Seattle, Washington. Family treatment targets the health problems associated with alcoholism and alcohol abuse in the Seattle Indian community. Conducted by the Seattle Indian Health Board. Funded by the Office of Minority Health, DHHS.**

- **Born Free Recovery Center, San Diego, California. This residential drug rehabilitation program for pregnant women includes detoxification, prenatal counseling, and courses on parenting skills.**

- **Oakland Parents in Action, Oakland, California. Community involvement strategies are combatting drug use and related crime in the predominantly Black neighborhoods of North Oakland. Funded by the San Francisco Foundation and the National Institute on Drug Abuse, DHHS.**

ALSO...

- **The Federal Government's Bureau of Health Care Delivery and Assistance has approved supplemental funding to community and migrant health centers to help them develop linkages with alcohol and drug abuse agencies and programs. Target populations include Asians and Pacific Americans, Blacks, Hispanics, Native Americans, Asian refugees, Hmongs, and other minorities with low income.**

DRUG ABUSE

Complications and Consequences

The illicit nature of drug abuse is a major obstacle in collecting sufficient and reliable data on the general population, and data on minority groups are even more scarce. Using the findings of the 1982 National Household Survey on Drug Abuse, the Task Force notes that there appears to be no difference in drug use prevalence between Whites and non-Whites in the household population. However, minorities are more likely to reside in inner city areas where prevalence of reported drug use is generally high compared to suburban or rural areas, so these groups may be at greater risk of drug abuse.

Apart from the addicting effects, drug use can cause serious health problems and can lead to sudden death through overdoses. Intravenous drug use increases the risk of contracting AIDS and hepatitis B. Again, national figures on drug-related mortality are scarce.

CLOSING THE GAP: Chemical Dependency and Minorities is one in a series of publications produced by the Office of Minority Health Resource Center focusing on each of the minority health priority areas. Other titles planned for this series are:

Cancer and Minorities
Diabetes and Minorities
Heart Disease, Stroke, and Minorities
Homicide, Suicide, Unintentional Injury, and Minorities
Infant Mortality, Low Birthweight, and Minorities

Other OMH-RC activities include a bilingually staffed toll-free number providing minority health information and referrals, a computerized database of materials, organizations, and programs, and a resource persons network of professionals active in the minority health field. For more information about any of these services, please call the Resource Center at 1-800-444-MHRC.

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FEDERAL RESOURCES

MINORITY SUBSTANCE ABUSE PREVENTION PROJECT
Office of Substance Abuse Prevention
Alcohol, Drug Abuse and Mental Health Administration
8401 Colesville Road, Box 350
Silver Spring, MD 20910
1-800-822-0047
(301)589-3272 (in MD)
Provides on-site technical assistance and regional training workshops to ethnic minority groups active in alcohol and drug abuse prevention.

NATIONAL CLEARINGHOUSE FOR ALCOHOL AND DRUG INFORMATION
P.O. Box 2345
Rockville, MD 20852
(301)458-2600
Provides consumer and professional information on alcohol and drug use and abuse. Special information is available on substance abuse among minorities.

NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION
Division of Alcohol Programs
400 Seventh Street, SW
Washington, DC 20590
(202)366-9581
Provides information and educational materials on drinking and driving.

OFFICE ON SMOKING AND HEALTH
Technical Information Center
Park Building, Room 1-10
5600 Fishers Lane
Rockville, MD 20857
(301)443-1690
Produces public education materials on smoking as well as materials for professionals on current research findings.

ODPHP NATIONAL HEALTH INFORMATION CENTER
P.O. Box 1133
Washington, DC 20013-1133
(800)336-4797
(301)565-4167 in MD
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CLOSING THE GAP

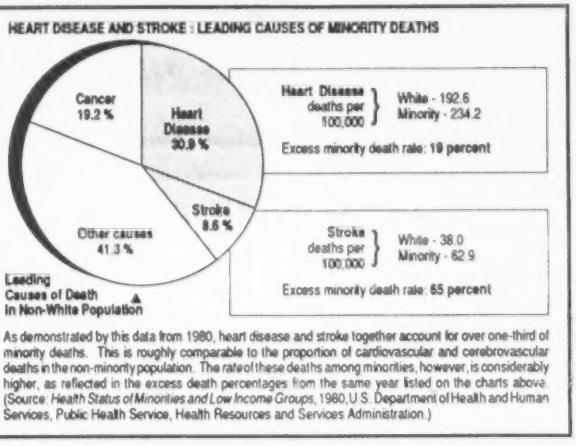
Heart Disease, Stroke, and Minorities

For the past generation the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 80 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the Office of Minority Health Resource Center (OMH-RC), has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority health areas. Each fact sheet describes the extent to which specific minority groups are affected, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information call the OMH-RC, toll-free, at 1-800-444-MHRC.

Minorities Are Hit Hard By Major Killers

Heart disease and stroke kill more people in the United States than any other disease, and minority groups are among those hardest hit. The Secretary's Task Force on Black and Minority Health found a wide gap between minorities and non-minorities in death rates for these diseases, a gap that extends in many cases to associated risk factors, such as high blood pressure.

The Task Force looked at data on heart disease and stroke among Asians and Pacific Islanders, Blacks, Hispanics, and Native Americans. It found much diversity, wide disparities, and hope for progress through prevention. The findings, statistics, and studies cited in this fact sheet come from the Task Force Report and reflect the data available in the early 1980s. Data were most plentiful for Blacks. Much less information was available for other groups; much more research is needed.


HEART DISEASE AND STROKE : LEADING CAUSES OF MINORITY DEATHS
Cancer 19.2 %
Heart Disease 30.9 %
Stroke 8.6 %
Other causes 41.3 %
Leading Causes of Death In Non-White Population
Heart Disease deaths per 100,000
White - 192.6
Minority - 234.2
Excess minority death rate: 19 percent
Stroke deaths per 100,000
White - 38.0
Minority - 62.9
Excess minority death rate: 65 percent

As demonstrated by this data from 1980, heart disease and stroke together account for over one-third of minority deaths. This is roughly comparable to the proportion of cardiovascular and cerebrovascular deaths in the non-minority population. The *rate* of these deaths among minorities, however, is considerably higher, as reflected in the excess death percentages from the same year listed on the charts above. (Source: *Health Status of Minorities and Low Income Groups*, 1980, U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration.)

Asians & Pacific Islanders

Japanese Men Have More Strokes, Filipinos More High Blood Pressure

Japanese men in the U.S. stand out from most other groups in having very high death rates from stroke. The reasons are not clear, although studies suggest that Japanese men in Hawaii smoke more than Japanese men in Japan. Other Asians and Pacific Islanders have stroke rates similar to those of non-minorities.

Another gap involves Filipino Americans, in whom high blood pressure is a significant public health problem. Filipino women, especially, are much more likely than non-minorities to have uncontrolled high blood pressure.

Other risk factors, such as smoking and cholesterol levels, appear to be low among Asians and Pacific Islanders, especially among Asian women. And when it comes to heart disease, Asians and Pacific Islanders have slightly lower death rates than the general population. The Task Force emphasized the need for more data in this area.

Blacks

Stroke Rate Among Blacks is Highest in U.S.

Black men are almost twice as likely to die from stroke as White men, and their death rate from stroke is more than double that of other minorities. Among Blacks, there is also a marked excess of high blood pressure, a major risk factor for stroke.

Heart disease is another killer of Blacks. Recent studies show that among Blacks 20 to 64 years of age, there is an excess of deaths from coronary heart disease compared to Whites. Excess mortality from coronary disease is more marked in Black women than in Black men.

The Task Force looked at research on these risk factors:

High blood pressure. High blood pressure is much more common among Blacks than other groups, but Blacks are beginning to gain control over this risk. "Between 1960-80, mean systolic pressures declined more in Blacks than in Whites," said the Task Force.

Cholesterol. Cholesterol levels among Black and White adults are about the same. Black men tend to have higher rates of the "good cholesterol," high density lipoprotein (HDL) cholesterol, which reduces cardiovascular risks.

Smoking. More Black men smoke than White men, although Whites tend to be heavier smokers.

Obesity. This risk factor for cardiovascular disease is more common among Black women than some other groups.

Socioeconomic status. Blacks—and other individuals—with lower educational levels and incomes tend to have higher blood pressures. Health experts don't know why this is so, but they have found, said the Task Force, that high blood pressure has been related to living "in areas of high social stress and instability as well as to education, coping styles, and occupational insecurity."

Hispanics

Obesity, Diabetes, Hypertension More Common in Some Groups

Some groups of U.S. Hispanics have more risk factors for heart disease and stroke than Anglos and other groups. Although statistics were not available for all Hispanic groups, studies of Mexican, Puerto Rican, and Cubans in the U.S. reveal these dangers:

- Obesity is much more common among Mexicans, especially women, than it is among the general population.
- Puerto Ricans, Cubans, and Mexicans are more likely to suffer from high blood pressure than Anglos.
- Older Mexican men have very high rates of high blood pressure, similar to Blacks, who have the highest rates.
- Mexicans, especially low-income men, have higher cholesterol levels than the general population.
- Diabetes, is a "major problem" among U.S. Hispanics, especially Mexicans and Puerto Ricans.

The Task Force emphasized that much more information should be gathered on the different groups. What data exist suggests that U.S. Hispanics in general have similar or slightly lower death rates for heart disease and stroke compared to Anglos, despite the high risk profiles of some groups.

Native Americans

Heart Disease Killing Many Under Age 35

"Under age 35, heart disease mortality for Native Americans is approximately twice as high as for all other Americans," reported the Task Force. And as Native Americans' life expectancy increases, so may their rates of heart disease.

Heart disease and stroke risks differ from tribe to tribe, but in general the Task Force found that obesity and diabetes, both linked to heart disease, were major health problems for Native Americans. In many tribes, more than 20 percent of the people have diabetes.

Other risk factors, such as cholesterol levels and high blood pressure, tend to be low in Native Americans. The Task Force noted that Native American lifestyles often involve more strenuous physical activity and less interpersonal competition than in the general population, factors that may protect against heart disease and stroke.

RISK FACTORS FOR STROKE

Hypertension is a major risk factor for stroke. The higher prevalence of hypertension in Blacks compared to Whites accounts in some part for the higher stroke incidence and mortality rates in Blacks. There is no apparent link between cholesterol levels or prevalence of smoking to risk of stroke.

National data for Asian Americans suggest that the stroke mortality rate is similar to that of Whites. However, a regional study on Japanese Americans shows a lower prevalence of hypertension and smoking, and lower cholesterol levels compared to Whites.

CARDIOVASCULAR AND CEREBROVASCULAR: WHAT'S THE DIFFERENCE?

Heart disease and stroke are everyday terms for cardiovascular and cerebrovascular disease.

Cardiovascular disease actually includes several different diseases of the heart and blood vessels. One of the most common is coronary heart disease, in which plaque builds up in the arteries around the heart, making them more narrow. These deposits consist mostly of cholesterol, a waxy substance that's produced by the body and also comes from food. Narrowing of the arteries may lead to a heart attack, when and if an artery becomes completely blocked.

Cerebrovascular disease, a more specific term for stroke, refers to diseases primarily affecting the brain. Strokes may be caused by the narrowing of arteries leading to the brain. Small fatty deposits or blood clots float up the arteries toward the brain, and plug up one of the main arteries. Some strokes are caused by a blood vessel breaking in the brain.

A risk factor is anything that increases a person's chance of developing a disease. Risk factors for heart disease and stroke are high blood pressure, smoking, high cholesterol levels, diabetes, and obesity.

CLOSING THE GAP
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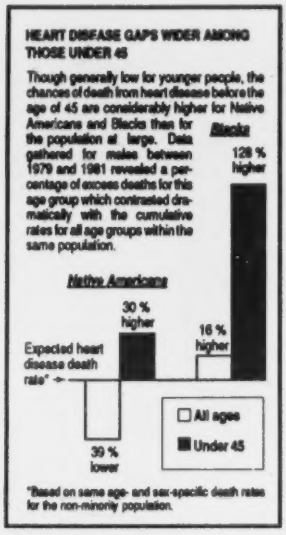
A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-MINC, toll free.


HEART DISEASE GAPS WIDER AMONG THOSE UNDER 45
Though generally low for younger people, the chances of death from heart disease before the age of 45 are considerably higher for Native Americans and Blacks than for the population at large. Data gathered for males between 1979 and 1981 revealed a percentage of excess deaths for this age group which contrasted dramatically with the cumulative rates for all age groups within the same population.
Blacks
128 % higher
Native Americans
30 % higher
16 % higher
Expected heart disease death rate*
39 % lower
All ages
Under 45
*Based on same age- and sex-specific death rates for the non-minority population.

Crosscutting Issues

Good Health Care Makes a Difference

Getting adequate medical care is especially important in preventing heart disease and stroke, but here too a gap exists between minorities and non-minorities.

The Task Force did not have statistics on medical care for all minority groups, but it did find that Blacks make fewer office visits to doctors than do Whites, use clinics and emergency rooms more, and are less likely to see heart specialists. Compared to Whites, Blacks see the medical care system as less accessible.

Medical care may be tied to socioeconomic status. People with low incomes do not see doctors as much as people with high incomes. This in turn may increase their risk of heart disease and stroke. One study, for example, shows that Hispanics with lower incomes run a greater risk of heart disease than Hispanics with higher incomes.

To change this picture, the Task Force recommended more research and urged that we find ways to "encourage earlier diagnosis, full use of all diagnostic procedures, and earlier treatment interventions so that minorities enter the delivery system well before an advanced disease state has developed."

Improving the Odds: You Can Reduce the Risk of Stroke and Heart Disease

Minorities can improve the odds in their favor, said the Task Force. Here is how:

- **Get blood pressure under control; check your blood pressure regularly and if it is high, follow a doctor's advice. It may take only a change in diet or smoking habits to control blood pressure.**
- **Quit smoking; this can improve the odds immediately and dramatically.**
- **Control cholesterol levels; eating foods low in animal fats can help lower cholesterol, many experts believe. Cut down on fatty meats, like bacon, sausage and pork, and foods fried in fat.**
- **Keep diabetes under control; a change in diet, losing weight, and taking medicine can help.**
- **Keep weight down; it's a matter of health, not looks. Obesity is a risk factor for heart disease and stroke.**
- **Exercise; regular physical activity can reduce the risk of these diseases.**

RISK FACTORS FOR CORONARY HEART DISEASE

The prevention of coronary heart disease (CHD) in minorities is hindered by the lack of data on these groups. This is especially true for Hispanics, who were designated as "Whites" in early studies, and for Asians, whose numbers were low when studies began in the 1950s and 1960s. This presents an obstacle in determining the impact of different risk factors and the effectiveness of treatment and control in each group. However, the Task Force notes that efforts are being made to collect data on minorities and their various subgroups.

The prevalence of definite hypertension in Blacks is 1.4 times greater than in Whites, despite a decline in mean blood pressure in Blacks between 1960 to 1980. While the Evans County 20-year study showed hypertensive Black men to be at lower risk for CHD, evidence from another study shows that reduction of blood pressure can reduce CHD incidence among both Whites and Blacks.

There appears to be a lower prevalence of hypertension in Native Americans, but the effect on CHD is unclear due to high mortality from other causes and a lack of data on tribal health differences. Regional data on Mexican Americans, Puerto Ricans, and Cubans indicate that prevalence of hypertension is greater compared to Anglos, though high blood pressure is less prevalent among Hispanics overall. Available data indicate that Hispanics are at lower risk for CHD than are Anglos.

Data on CHD risk factors and mortality for Asian Americans is available only from regional studies on Japanese and Filipino Americans. Japanese Americans exhibit a lower prevalence of hypertension than Whites, although this pattern is influenced by demographic and socioeconomic variables. Filipinos have higher blood pressure than Whites in all gender and age categories.

Minorities do not appear to be at greater risk than non-minorities with regard to cholesterol levels. Blacks and Whites have comparable mean cholesterol levels. Obesity is common in Black women and may be a factor in their higher CHD mortality compared to White women. Certain Hispanic subgroups such as Mexican Americans and Puerto Ricans exhibit higher cholesterol levels than Anglos, and there is a higher prevalence of obesity among Hispanics in regional studies, but there is insufficient data to determine why Hispanics appear to have lower CHD risk despite this. Both Native Americans and Japanese Americans show lower cholesterol levels than Whites.

Although heavy smoking is less prevalent in Blacks than in Whites, smoking appears to increase the risk of CHD mortality similarly in Blacks and Whites. The prevalence of smoking in other minority groups appears to be lower than in Whites.

Diabetes mellitus is a serious problem among Hispanics and Blacks, but the effects of this disease on CHD have not been adequately studied among any minority group.

Gaining Ground: Minorities Are Working To Close Stroke and Heart Disease Gaps

Groups throughout the country have started programs to help reduce stroke and heart disease risks. Here are some examples; for more information, contact the OMH-RC.

- **Pueblo Hispanic Heart Risk: Diet and Obesity, Pueblo, Colorado.** Young Hispanic families develop and establish healthier lifestyles through this program, which aims to reduce the rates of cardiovascular disease. Conducted by the Pueblo City-County Health Department. Funded by the Office of Minority Health, DHHS.
- **Cardiovascular Disease Risk Reduction Campaign, Seattle, Washington.** This Black community program works to reduce morbidity and mortality from cardiovascular disease. Conducted by the Sound Heart Program of the Central State Community Health Center. Funded by the Office of Minority Health, DHHS.
- **Diet-Smoking-Blood Pressure Control for Blacks, Nashville, Tennessee.** Health professionals, Black church workers, and lay people are trained to address the risk factors of diet, obesity, smoking, and high blood pressure. Conducted by Meharry Medical College. Funded by the Office of Minority Health, DHHS.
- **Minority Hypertension Detection and Control Program, Cleveland, Ohio.** High risk Black and Hispanic males are reached through local screening sites with intensive followup, referral, and tracking systems. Conducted by the Greater Cleveland High Blood Pressure Coalition. Funded by the Office of Minority Health, DHHS.
- **Community Health Assessment and Promotion Project, Atlanta, Georgia.** Obesity and sedentary lifestyles are the target of this minority community program. Conducted by the Department of Community Health, Emory University School of Medicine.
- **Fitness Through Churches Project, Durham, North Carolina.** This program trains church members as aerobic fitness and health advocates, who then return to their churches to establish fitness programs and share information on smoking cessation, blood pressure control, nutrition, and fitness. Sponsored by the University of North Carolina at Chapel Hill. Funded by the American Heart Association.
- **Community Based Program: Risk Reduction/Health Education, Middletown, Connecticut.** Women from three predominantly Black churches are involved in a highly structured education program consisting of lectures, cooking demonstrations, taste testing, and preparation of a church supper using special recipes. Sponsored by the Middletown Department of Health.
- **Monmouth Hypertension Control Project, Monmouth, New Jersey.** Focusing on several target groups, including Blacks and Hispanics, the Project has established high blood pressure screening activities at permanent sites such as food stores, pharmacies, the county courthouse, and businesses.
- **Columbus Satellite Program, Columbus, New Mexico.** Two satellite clinics provide health services to border area residents of Columbus, New Mexico, and Palamas, Mexico, as well as to seasonal migrant workers. Included are high blood pressure screening and followup services. Sponsored by the Luna County Health Office.

CLOSING THE GAP: Heart Disease, Stroke, and Minorities is one in a series of publications produced by the Office of Minority Health Resource Center focusing on each of the minority health priority areas. Other titles in this series are:

Cancer and Minorities
Chemical Dependency and Minorities
Diabetes and Minorities
Homicide, Suicide, Unintentional Injury, and Minorities
Infant Mortality, Low Birthweight, and Minorities

Other OMH-RC activities include a bilingually staffed toll-free number providing minority health information and referrals, a computerized database of materials, organizations, and programs, and a resource persons network of professionals active in the minority health field. For more information about any of these services, please call the Resource Center at 1-800-444-MHRC.

CLOSING THE GAP
Office of Minority Health Resource Center
A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-MHRC, toll free.

FEDERAL RESOURCES

NATIONAL HEART, LUNG, AND BLOOD INSTITUTE
Building 31, Room 4A-21
9000 Rockville Pike
Bethesda, MD 20892
(301)496-4236
Offers information on current research in heart disease.

NATIONAL INSTITUTE OF NEUROLOGICAL AND COMMUNICATIVE DISORDERS AND STROKE
Building 31, Room 8A-06
9000 Rockville Pike
Bethesda, MD 20892
(301)496-5924
Offers information on current research in stroke and cerebrovascular disease.

NATIONAL HIGH BLOOD PRESSURE EDUCATION PROGRAM INFORMATION CENTER
Suite 530
4733 Bethesda Avenue
Bethesda, MD 20814
(301)951-3260
Provides public and professional information on high blood pressure.

NHLBI SMOKING EDUCATION PROGRAM INFORMATION CENTER
Suite 530
4733 Bethesda Avenue
Bethesda, MD 20814
(301)951-3260
Provides information on smoking and quitting smoking for the public and health professionals.

NATIONAL CHOLESTEROL EDUCATION PROGRAM INFORMATION CENTER
Suite 530
4733 Bethesda Avenue
Bethesda, MD 20814
(301)951-3260
Provides information on elevated blood cholesterol levels for the public and health professionals.

ODPHP NATIONAL HEALTH INFORMATION CENTER
P.O. Box 1133
Washington, DC 20013-1133
(800)336-4797
(301)565-4167 in MD
Provides referrals to health organizations, including those concerned with minorities.

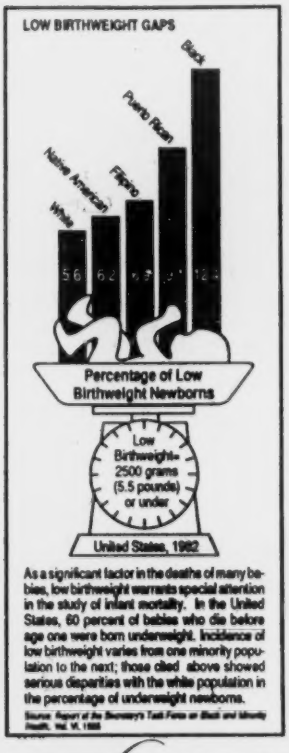
AND DON'T FORGET...

OFFICE OF MINORITY HEALTH RESOURCE CENTER
P.O. Box 37337
Washington, DC 20012-7337
1-800-444-MHRC (6472)
Answers requests from consumers and professionals on minority health—issues, risk factors, resources, and programs.

CLOSING THE GAP

Infant Mortality, Low Birthweight, and Minorities

For the past generation the United States, as a whole, has enjoyed improvement in the health status of its people. Despite this fact, there continues to be disparity in deaths and illnesses experienced by its racial/ethnic minority populations. In early 1984, the Secretary's Task Force on Black and Minority Health was formed to analyze this disparity. The Task Force identified six health problem areas that account for more than 80 percent of excess deaths among U.S. minorities, and generated an extensive set of recommendations geared toward improving the health of minority populations. The Office of Minority Health (OMH) was established to stimulate the development of programs and to coordinate, monitor, and advocate for a national strategy to ensure implementation of the Task Force's recommendations. In an effort to increase public awareness of these health disparities, the **Office of Minority Health Resource Center (OMH-RC)**, has prepared a series of fact sheets, based on the *Report of the Secretary's Task Force on Black and Minority Health*, on each of the six minority health priority health areas. Each fact sheet describes the extent to which specific minority groups are affected, details avenues for prevention, and offers other sources of assistance. For additional fact sheets and more information call the OMH-RC, toll-free, at 1-800-444-MHRC.



As a significant factor in the deaths of many babies, low birthweight warrants special attention in the study of infant mortality. In the United States, 60 percent of babies who die before age one were born underweight. Incidence of low birthweight varies from one minority population to the next; those cited above showed serious disparities with the white population in the percentage of underweight newborns.

Source: Report of the Secretary's Task Force on Black and Minority Health, Vol. VI, 1985

Minority Babies Dying Before Age 1

Thousands of babies in the United States die during their first year, and babies who belong to minority groups have less chance than others of reaching their first birthday. Definite and in some cases very wide gaps in infant death rates divide minorities from non-minorities, according to the Task Force Report.

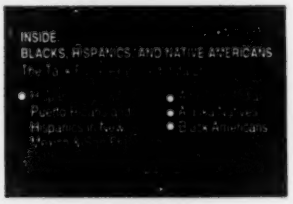
The Task Force looked at infant mortality rates and risks for Asian and Pacific Islander, Black, Hispanic, and Native American babies. It found much diversity, wide disparities, and hope for progress through prevention. Low birthweight, a factor in 60 percent of infant deaths, received special attention. The findings, statistics, and studies cited in this fact sheet come from the Task Force Report and reflect the data available in the early 1980s. Data were most plentiful for Blacks. Much less information was available for other groups; much more research is needed.

Asians & Pacific Islanders

Birthweights and Prenatal Care Rates Lower For Some Groups

Some Asian and Pacific Islander groups—and like other minorities they are a diverse population—tend to have babies born with low birthweight. Statistics are scarce, and the Task Force did not have enough data to get a complete picture of infant mortality and low birthweight in any one subgroup. But the few studies available did reveal the following gaps:

- The percentage of low birthweight among Asian and Pacific Islander babies in the United States was not high—6.5 percent in 1980—but it was still higher than the White rate of 5.6 percent.
- The low birthweight rate differed among groups, with the Chinese at 4.8 percent, the Japanese at 6.2 percent, and the Filipinos at 7.4 percent.
- Prenatal care rates were slightly below those of Whites with 75 percent of all Asians beginning care in the first 3 months of pregnancy compared to about 81 percent of Whites. Among Asians, the Japanese were more likely to begin care early and less likely to have received little or no care.



Blacks

Infant Deaths Twice As High; Lack of Prenatal Care May Be a Factor

Black babies die in their first year of life at twice the rate of White babies. Rates of low birthweight among Blacks are also very high, but low birthweight is not the only factor in infant deaths, said the Task Force. Even normal weight Black babies have much higher mortality rates.

Looking at a breakdown of these statistics, the Task Force found that Black deaths are high for both the neonatal and postneonatal periods. Postneonatal death rates are higher among Blacks for all major causes of death except congenital anomalies, or birth defects.

The gap between Blacks and Whites extends to prenatal care. Black mothers are twice as likely as White mothers to receive either no care or care that doesn't begin until the last 3 months of pregnancy. Some studies show that prenatal and other medical care received by mother and baby affects neonatal death rates: the less care received, the more likely the baby is to die in the neonatal period.

INFANT MORTALITY TERMS

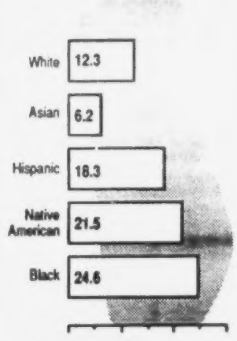
Infant mortality has two main components. Neonatal mortality refers to deaths within the first 28 days of life; neonatal mortality has declined in the last two decades but still accounts for most infant deaths.

Postneonatal mortality refers to deaths from 28 days to 1 year. In the early part of the century, more babies died in the postneonatal period than in the neonatal period; the situation is now reversed.

Low birthweight is defined as 2,500 grams (about 5½ pounds) or less. Low-birthweight babies may be premature but they also may be babies who simply did not gain enough weight before they were born.

ADOLESCENT PREGNANCY: A HEALTH ISSUE

A reduction in the high adolescent pregnancy rate (demonstrated in the chart below) would help decrease the incidence of low birthweight and infant mortality. The neonatal mortality rate among teenaged mothers is 1.5 times as high as that of mothers over age 20. In 1978, 24 percent of low birthweight infants were borne by teenaged mothers. Pregnancy during adolescence also increases the dangers of maternal health. The adolescent maternal death rate compared to that of women in their early 20s is 35 percent higher for mothers aged 15-19, and 60 percent higher for mothers aged 14 and under.



Percentage of live births to women 19 years old and under

Source: Report of the Secretary's Task Force on Black and Minority Health, Vol. VI, 1985

Hispanics

Some Groups of Hispanics Are at High Risk for Infant Death

Hispanic groups differ in their rates of infant mortality, low birthweight, and prenatal care, but some have serious problems. Puerto Rican babies, for example, are often born with low birthweight. In general, postneonatal mortality is high among Hispanics, and prenatal care is low. A Texas report estimated that postneonatal mortality was 60 percent higher for Mexican Americans in that State than for Anglos.

Hispanics are less likely than Anglos to receive early prenatal care, but rates vary widely, with 80.1 percent of Cuban mothers beginning care in the first 3 months of pregnancy; 60.1 percent of Mexicans; 58.3 percent of Central and South Americans; and 54.2 percent of Puerto Ricans. The rate for Anglos is 81 percent.

From the limited data available, rates of low birthweight are not high among Hispanics compared to Anglos, except for Puerto Ricans. The rate is 5.8 percent for Cubans; 5.7 percent for Mexicans; and 9.1 percent for Puerto Ricans. The rate for Anglos is 5.6 percent.

Native Americans

Unintentional Injuries and Sudden Infant Death Killing Many Babies

American Indian and Alaska Native babies have a far better chance of survival than they did 35 years ago. The infant mortality rate for Native Americans dropped a dramatic 76 percent between 1954 and 1980. But a gap in infant mortality between Native Americans and non-minorities remains; postneonatal deaths are particularly high among Native Americans.

Unintentional injuries, or accidents, are a major cause of these postneonatal deaths, as is sudden infant death syndrome (SIDS), sometimes known as crib death. One study of Navajos showed that infections and congenital anomalies, or birth defects, accounted for many deaths in the postneonatal period. Congenital anomalies may be associated with diabetes and alcohol use, both high among Native Americans.

Prenatal care rates are low for Native Americans. According to one study, about 23 percent fewer American Indian women than White women receive care in the first 3 months of pregnancy. Within various subgroups of the study, those with better patterns of care had fewer babies with low birthweight.

Impact on Infant Health
UNINTENTIONAL INJURY

Automobile child safety seats are estimated to be up to 60 percent effective in reducing fatalities and up to 80 percent effective in reducing injuries, according to the *Report on the 1990 Health Objectives For the Nation*. All 50 states and the District of Columbia now enforce automobile child restraint use laws; however, not all hospitals and clinics provide child safety seats for newborns being taken home.

CLOSING THE GAP
Office of Minority Health Resource Center

A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-MHRC, toll free

Crosscutting Issues

Social, Economic Factors Contribute to Higher Risk

Researchers have found that many of the risk factors associated with infant deaths and low birthweight are related to social and economic conditions. The Task Force noted these risk factors in particular:

1. Low-income and not enough insurance to get appropriate medical care
2. Pre-existing disease conditions
3. Poor nutrition
4. Inadequate housing and crowded living conditions
5. Limited maternal education
6. Stressful work environments
7. Disrupted families and lack of social supports
8. Problems of transportation and child care that impede use of services

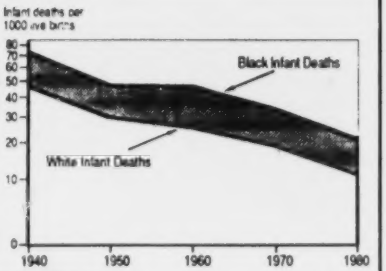
All these situations are more common among low-income and minority women. In addition, populations with poor pregnancy outcome often include more teenage mothers and more unmarried mothers and have more unintended births.

Some risk factors exert more influence on neonatal deaths. Experts believe that neonatal deaths reflect the preexisting health of the mother and the medical care she and her baby received during pregnancy and around the time of delivery. Postneonatal mortality, on the other hand, may reflect living conditions, quality of care for children, and medical care for treatable conditions, such as infections.

"The roles of socioeconomic status and access to care remain paramount," concluded the Task Force; it recommended more research to "improve our understanding of the relationships among individual, societal, health service delivery, and financing factors which combine to influence the health of our Nation's babies."

INFANT DEATH RATE DECLINES—GAP PERSISTS

Medical advances and improved access to health care contributed to a dramatic decline in infant death among all segments of the United States population between 1940 and 1980. Progress, however, did not extend to any appriciable decrease in the disparity between Black and White infant mortality rates—a gap which remains virtually unchanged over the 40 year period. (Vertical axis arranged logarithmically to express proportional relationship.)



Source: *Report of the Secretary's Task Force on Black and Minority Health*, Vol. VI, 1985

Impact on Infant Health: CHEMICAL DEPENDENCY

Alcohol abuse by pregnant women can lead to the condition known as Fetal Alcohol Syndrome (FAS). This condition appears in one of 750 live births and is characterized by birth defects and low birthweight. Minority data are available only for Native Americans; the incidence of FAS among the various tribes ranges from 1.3 to 10.3 cases per 1,000 live births.

Maternal drug abuse can have serious consequences for the unborn infant as well. Children born to mothers who used cocaine often suffer withdrawal problems at birth, and they also have higher incidence of kidney and pulmonary disorders, developmental retardation, and visual and coordination problems. Women addicted to heroin or other narcotics put their infants at risk to be born addicted or to have low birthweights.

In general, smokers have double the proportion of low birthweight outcomes compared to non-smokers. The weight reduction appears proportional to the number of cigarettes smoked and independent of demographic factors. See the *Closing the Gap* issue on Substance Abuse and Minorities for more information.

Improving the Odds: Healthy Pregnancies, Healthy Babies

The odds can be improved for minority babies, their risk of death reduced, their chance of good health increased. Here are some areas in which the Task Force noted opportunities for progress:

Family planning. We should enhance personal reproductive responsibility through more education, improved family planning services, and further research. Family planning and pregnancy prevention is especially important among teenagers, given the disproportionate number of teen parents who are minority women.

Prenatal care. It is important to assure early and continuous prenatal care and appropriate levels of maternity, newborn, and infant care to minority women. We should explore ways to increase minority women's knowledge of risks during pregnancy and the value of early and ongoing prenatal care.

Financial barriers. Many minority women, especially teenagers, receive prenatal care through Federal or State subsidized services or must pay for their own care. It is important to lower financial barriers to care and to adequately finance the providers and hospitals that care for minority women.

Services. High-risk women often need more services than others. Services should include expanded nutrition supplements, health education, screening for conditions such as hepatitis and diabetes during pregnancy, and provider and patient education on risk assessment and recognition of preterm labor. Arbitrary limits to services should be removed.

Information and education. We must expand patient education for on risk factors for infant mortality. Comprehensive health education for providers and information campaigns for the public should address avoidable risks during pregnancy.

A nationwide service of the Office of Minority Health, Public Health Service, Department of Health and Human Services 1-800-444-MHRC, toll free. • CLOSING THE GAP Office of Minority Health Resource Center

Gaining Ground: Minorities Are Working to Close Infant Mortality and Low Birthweight Gaps

Groups throughout the country have started programs to help reduce infant mortality rates. Here are a few examples. For more infromation, contact the Office of Minority Health Resource Center:

- **Asian Community Program, Seattle, Washington:** Bilingual Asian women in this program are improving the access of other Asian women to prenatal care services by reducing communication barriers. The Program is also preparing bilingual manuals on pregnancy, labor, delivery, and postpartum care. Sponsored by the March of Dimes Foundation in Seattle.

Impact on Infant Health:
DIABETES

Perinatal death occurs in four to eight percent of diabetic pregnancies, a figure which is two to four times greater than that in nondiabetic pregnancies. Five to ten percent of diabetic infants have major congenital abnormalities, and one third of these cases are fatal. Diabetic infants are also at high risk for respiratory distress, jaundice, and low blood glucose and calcium levels.

Improvements in prenatal and postnatal care have reduced these figures drastically in the past two decades, but minorities still have higher rates for infant mortality and low birthweight in part because of the high incidence of diabetes in the groups. Black women are 50 percent more likely to develop diabetes than White women; Hispanics as a whole are 3 times more likely; and Native Americans are 10 times more likely to develop diabetes than Whites. See the *Closing the Gap* issue on Diabetes and Minorities for more information.

- **La Comadrona Program, Hartford, Connecticut:** This program is training Hispanic women to provide information on prenatal care and family planning to their communities. Sponsored by the Hispanic Health Council.
- **Ethnic Adolescent Family Life Project, Providence, Rhode Island:** Blacks, Hispanics, Portuguese, Southeast Asians, and other ethnic minorities are served in this program in five inner-city health centers. The Project matches pregnant teens with bilingual/bicultural peer counselors who provide social support and information on prenatal care, childbirth, and infant care. Conducted by the Providence Ambulatory Health Care Foundation with funds from the Office of Adolescent Pregnancy Programs, DHHS.
- **HealthStart, New Jersey:** This model program is designed to improve the quality of prenatal health care services for low-income women in an effort to reduce infant mortality. A program of the New Jersey Department of Health.

ALSO...

- Federal funds have been appropriated to expand area health education centers that teach prenatal care in impoverished areas along the Mexican border. And another Federal appropriation will fund nurse practitioner/nurse midwife fellowships in health centers that serve populations with high infant mortality rates, including American Indians and Native Hawaiians.

CLOSING THE GAP: Infant Mortality, Low Birthweight, and Minorities is one in a series of publications produced by the Office of Minority Health Resource Center focusing on each of the minority health priority areas. Other titles in this series are:

Cancer and Minorities
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Homicide, Suicide, Unintentional Injury, and Minorities

Other OMH-RC activities include a bilingually staffed toll-free number providing minority health information and referrals, a computerized database of materials, organizations, and programs, and a resource persons network of professionals active in the minority health field. For more information about any of these services, please call the Resource Center at 1-800-444-MHRC.

FEDERAL RESOURCES

Call or write the following Federal offices for information on infant mortality and associated risk factors.

FAMILY LIFE INFORMATION EXCHANGE
P.O. Box 10716
Rockville, MD 20850
(301)770-3642
Distributes materials on family planning, adolescent pregnancy, and adoption. Primarily serves Title X and Title XX clinics.

NATIONAL CENTER FOR EDUCATION IN MATERNAL AND CHILD HEALTH
38th and R Streets, NW
Washington, DC 20057
(301)625-8400
Provides comprehensive information on maternal and child health issues including information on prenatal care, infant mortality, and adolescent pregnancy.

NATIONAL SUDDEN INFANT DEATH SYNDROME INFORMATION CLEARINGHOUSE
Suite 600
8201 Greensboro Drive
McLean, VA 22102
(703)821-8955
Offers information for consumers and professionals on sudden infant death syndrome (SIDS), infantile apnea, and death and grieving.

OFFICE OF ADOLESCENT PREGNANCY PROGRAMS
Room 736E
200 Independence Avenue, SW
Washington, DC 20201
(202)245-7473
Provides information on adolescent pregnancy, teenage sexual activity, and federally funded programs for prevention.

NATIONAL INSTITUTE OF CHILD HEALTH AND HUMAN DEVELOPMENT
Office of Research Reporting
Building 31, Room 2A32
9000 Rockville Pike
Bethesda, MD 20892
(301)496-5133
Distributes consumer materials on a variety of topics including prenatal care, pregnancy and childbirth, and premature birth. Professional information is available on topics such as sudden infant death sydrome, pregnancy and perinatology, and contraception.

ODPHP NATIONAL HEALTH INFORMATION CENTER
P.O. Box 1133
Washington, DC 20013-1133
(800)336-4797
(301)565-4167 in MD
Provides referrals to health organizations, including those concerned with minorities.

AND DON'T FORGET...

OFFICE OF MINORITY HEALTH RESOURCE CENTER
P.O. Box 37337
Washington, DC 20013-7337
1-800-444-MHRC (6472)
Answers requests from consumers and professionals on minority health, risk factors, resources and programs.

APPENDIX 2

Minority Elderly New Yorkers

The Social and Economic Status
of a
Rapidly Growing Population

NYS OMH
Bureau of Long Term Care
JUN 22 1989
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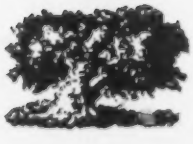

New York State Office for the Aging

Minority Elderly New Yorkers

The Social and Economic Status
of a
Rapidly Growing Population

New York State Office for the Aging

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Preface

The minority elderly of New York State represent a wealth of cultural and national heritages found in few places in this country and rarely in other parts of the world. They are the Black aged, the Hispanic aged, and elderly Native Americans, Asians and Pacific Islanders. Each of these minority groups represents many different cultures and national origins. Together they form a population numbering almost half a million persons that is growing by more than 25,000 persons annually--a rate of growth that will almost double the size of the minority elderly population by the year 2000.

This report provides a comprehensive examination of the current status and quality of life of the minority elderly in New York State. It focuses on the minority household population aged 60 and older, exclusive of persons in long term care facilities and other group quarters. Findings are based largely on data for New York State from the March 1985 Current Population Survey conducted by the U.S.Bureau of the Census.

The current status of the minority elderly in the State can not be divorced from the realities of discrimination and racism which are part of America's history. Born in the 1890's and early decades of this century, most of today's minority elderly population has lived through a major part of this history. The affects of unequal opportunity, spawned by discrimination, are too readily apparent in the current status and disadvantaged living conditions of many minority elderly persons today.

This report documents the double jeopardy of being both a minority and elderly person, and of experiencing disadvantaged living conditions further aggravated by the economic losses associated with growing old. But it also describes a minority elderly population that includes many persons who are active in the labor force, many retirees who have incomes adequate for discretionary as well as basic day-to-day expenses, and many persons who have recently moved to New York State from other states and abroad.

The current status of the minority elderly in New York State is characterized on the one hand by their very diverse backgrounds and current living conditions. On the other, a large segment of the minority elderly population faces extensive economic poverty from years of discrimination and more recent losses of old age.

Together, this diversity and economic poverty are a major challenge to the development of public policy and programs for and on behalf of the minority elderly. The devestating effects of poverty and rapid growth in the number of minority elderly New Yorkers make this challenge compelling and immediate.

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Executive Summary

This report describes the current status and living conditions of the minority elderly population of New York State. It focuses on the minority household population aged 60 and older, exclusive of persons in long term care facilities and other group quarters, and is based on data for New York State from the March 1985 Current Population Survey conducted by the U.S.Bureau of the Census. A variety of other data sources are used to examine the composition and growth of the minority elderly population.

The 'minority' elderly are defined in this report as the Black and Hispanic aged, and elderly Native Americans, Asians and Pacific Islanders. 'Elderly' is defined as 60 years of age and over, and is used interchangably with 'older' and 'aged.'

Selected findings are presented describing the rapid growth of the State's minority elderly population, and the diverse background and socio-economic characteristics of the almost half a million minority elderly persons in New York State in 1985. Pervasive throughout are findings indicative of discrimination and unequal opportunity. The historic lack of educational and employment opportunities, the affects of a shorter life expectancy and the earlier loss of a spouse, and the added jeopardy of growing old, are perhaps most clearly seen in the economic poverty which is extensive and highly concentrated among minority elderly New Yorkers.

POPULATION GROWTH

- In 1980 the total minority elderly (aged 60-plus) population of New York State numbered over 392,000 and was comprised of persons representing over thirty different cultural and national origins.

- By 1985 the number of minority elderly living in households in the State approached the half million mark--a population estimate of 474,439 including more than 270,000 Black aged and 153,000 Hispanic aged.

- In 1990 the minority elderly are projected to number 603,000--an increase of 27 percent from 1985--and to comprise 19 percent of all elderly New Yorkers, in comparison to 16 percent in 1985 and only 13 percent in 1980.

- Assuming this rapid growth continues, by the year 2000 the minority elderly in New York State will number a projected 863,000 and include 452,000 Black aged and 362,000 Hispanic aged.

CAUSES OF GROWTH

- "Aging-in" is contributing substantially to the dramatic growth of the minority elderly population, particularly among the Black aged. Younger cohorts of Black New Yorkers, which swelled in size during the 1960's and

early 1970's, are turning 60 years old. Aging-in of younger persons will continue to expand the ranks of the minority elderly through the year 2000.

- Recent migration into New York State from other states and abroad is further adding to this population growth, particularly among the Hispanic aged. Seven (7) percent of the Hispanic persons aged 60 or older in 1985 had moved to New York State in the five years since the 1980 Census.

- Increases in life expectancy are also contributing to the growth of the minority elderly population. However, the life expectancy of the minority elderly remains much shorter than that of the White population. The minority elderly die younger than the non-minority elderly, even though they suffer the same leading causes of death, i.e., heart disease, cancer, cerebrovascular disease, pneumonia and influenza, and diabetes mellitus.

SOCIO-DEMOGRAPHICS

- The minority elderly and particularly the Hispanic elderly are younger than other older New Yorkers. This is due to higher mortality and also reflects the more rapid growth of younger minority elderly cohorts from aging-in and in-migration. Only 22 percent of the minority elderly, and 17 percent of the Hispanic aged in 1985 were aged 75 or older--in comparison to 29 percent of the non-minority elderly.

- Women outnumber men among the minority elderly by a ratio of 58 to 42. Men continue to experience a shorter life expectancy than women among the minority as well as the non-minority elderly.

- Today's minority elderly were not afforded equal educational opportunities and therefore do not have the past formal education of the rest of the elderly population. Fourteen (14) percent of the minority elderly in 1985 had attended college, but 51 percent had not completed a school grade beyond elementary. In comparison, 22 percent of the non-minority elderly had attended college, while only 26 percent had not attended beyond elementary school.

- Poorer economic and living conditions have placed major stress on the marriages and nuclear families of the minority elderly. The minority elderly also lose their spouses to death earlier than the rest of the elderly population. Almost four-in-ten or 38 percent of the minority elderly in 1985 were widowed, and an additional 12 percent were currently divorced or separated--in comparison, respectively, to 31 and 4 percent of the non-minority elderly.

- The living arrangements of the minority elderly reflect their marital status. They are more likely to live alone than other elderly persons. They are also more likely to be forced by poverty to live in extended families where both young and old are often poor. One-in-three or 32 percent of the minority elderly in 1985 lived alone in one-person households--in comparison to 28 percent of other elderly persons. An additional 10 percent of the minority elderly lived in households with four-or-more members--in comparison to only 9 percent of the rest of the elderly population.

GEOGRAPHIC LOCATION

- The minority elderly population is highly concentrated in the central cities of New York State. Four-out-of-five or 81 percent had their homes in these larger cities in 1985, in comparison to just 47 percent of all older New Yorkers.

- The geographic residence pattern of the minority elderly has major implications for the targeting of public resources. Recent estimates by the U.S.Bureau of the Census show that only 7 of the 62 counties in New York State have minority elderly populations which constitute as much as 5 percent of all elderly persons in the county. Three-fourth or 74 percent of the minority elderly lived in the 5 counties of New York City alone in 1985, constituting an estimated 30 percent of the City's total elderly population.

RESIDENTIAL MOBILITY

- The minority elderly, particularly the Hispanic aged, are more likely to change homes, and move to a different apartment or house than the non-minority elderly. One-in-three or 31 percent of the Hispanic elderly in 1985 had changed homes since 1980, including 6 percent who had moved to New York State and 25 percent who had changed homes within the State. In comparison all but 12 percent of the non-minority elderly were living in the same home in 1985 as they had occupied in 1980.

TENURE AND TYPE OF HOUSING

- The housing units occupied by the minority elderly are typified by the kind of housing available in the central cities of the State. The minority elderly live predominantly in rented housing units, most of which are in larger apartment buildings. Sixty-two (62) percent of the minority elderly in 1985 lived in rented housing with 43 percent living in buildings with at least ten units.

- The minority elderly's housing also reflects a high concentration of poverty and low income. A disproportionate small number of the minority elderly own their homes, while a disproportionate large number live in public and rent subsidized housing. The minority elderly constituted 10 percent of the elderly living in owner occupied homes in 1985, but 20 percent of the elderly living in public and subsidized housing which affords lower rents to persons with low incomes.

EMPLOYMENT

- The minority elderly are just as likely to be employed as other elderly New Yorkers, but in lower paying occupations that reflect the unequal opportunities minorities have faced in employment and education. Twenty-five (25) percent of both the minority and non-minority elderly populations in 1985, had been employed during the prior year. Of those employed however, only 35 percent of the minority elderly--in comparison to 62 percent of the non-minority elderly--had worked in "white collar" professional, administrative support, sales or business positions.

- While the minority elderly are just as likely to be working, they are more likely to be kept from working by poor health. Sixteen (16) percent of the minority elderly in 1985 did not work during the prior year because of illness or disability--in comparison to only 8 percent of the non-minority elderly.

PERSONAL INCOME

- The average personal income of the minority elderly population is well below the already low average income of the total elderly population. In 1985 the minority elderly had a median income during the prior year of only $5,600 or less than $467 a month--one-third less than the $8,326 median income of the non-minority elderly.

- The double jeopardy of old age and minority status is an economic fact of life for most minority elderly New Yorkers. While the minority elderly comprised 16 percent of the State's elderly population in 1985, they received only 11 percent of the elderly's aggregate income during the prior year. At one extreme, 3 percent of the elderly's aggregate income was received by that 9 percent of the elderly who were minority elderly persons with incomes of under $6,000 a year. At the other extreme, 37 percent of the elderly's aggregate income was received by that 10 percent of the elderly who were non-minority elderly persons with annual incomes of $25,000 or more.

SOURCES OF INCOME

- The minority elderly have fewer sources of income than the non-minority elderly and receive less income from those sources they do have.

- The minority elderly rely heavily on earnings from employment and Social Security benefits for most of their income. Still, the minority elderly receive smaller incomes from these sources, and are less likely to receive Social Security benefits than the non-minority elderly. Earnings from employment provided a relatively high income--a mean of $11,128--for 25 percent of the minority elderly, but most (75 percent) had no income from earnings. Social Security benefits provided a mean income of $4,396 for approximately two-thirds of the minority elderly, but one-in-three received no Social Security benefits.

- A disproportionate small number of the minority elderly have income from interest on savings or other "property" income, and income from pensions or retirement funds. Only 34 percent of the minority elderly had income from interest or other "property" sources, while only 17 percent received retirement pension income--in comparison, respectively, to 70 and 30 percent of the non-minority elderly.

- Many minority elderly persons are dependent on Social Security for all their income, and on Supplemental Security Income (SSI) payments which raise total income to the levels afforded under the SSI program. One-in-four or 24 percent of the minority elderly received income from ONLY Social Security in 1984. An additional 14 percent received income supplement payments under the SSI program.

POVERTY AND INCOME STATUS

- The minority elderly experience very high rates of poverty. A total of 43 percent--more than two-out-of-five minority elderly persons in the State--were living below or in marginal poverty in 1984, including 45 percent of the Black aged and 47 percent of the Hispanic aged.

- Below-poverty incomes among the minority elderly reflect the limited amount and sources of their income, and the level of benefits and supplemental payments afforded by public policy under Social Security and the SSI program. Twenty-six (26) percent of all minority elderly New Yorkers were living below the official federal poverty threshold--including 25 percent of the Black aged, and 32 percent of the Hispanic aged in the State.

- Many more minority elderly live on incomes at the marginal poverty level (i.e., from 100% to 150% of official federal poverty thresholds). A marginal poverty income affords, at best, a subsistance standard of living which is extremely vulnerable to the higher medical expenses and regional costs-of-living often experienced by minority elderly New Yorkers. Eighteen (18) percent of the minority elderly were living in marginal poverty, including 20 percent of the Black aged and 15 percent of the Hispanic aged.

Introduction: Defining the Population

The minority elderly of New York State are a diverse cultural and socio-economic population. The population includes every race and represents many of the world's cultures, from Native Americans and the American Black population to first and second generation immigrants with national and ethnic backgrounds spanning the globe.

The minority elderly population is generally comprised of the Black and Hispanic aged, the two largest minority groups, and the elderly of the American Indian, Eskimo, Aleutian, Asian, and Pacific Islander populations. In all, the minority elderly account for a substantial and growing segment of the total elderly population of New York State.

This report describes the dramatic growth of the minority elderly population, and presents demographic and socio-economic profiles of the minority elderly household population of New York State. While presenting data from a variety of sources, the following terms are used consistently throughout:

- 'Elderly' is defined as 60 years of age and older, and is used interchangeably with 'older' to refer to persons aged 60 or older.
- 'Minority' is defined as being either Hispanic, Black or of other minority races.[1] Conversely, 'non-minority' is defined as being non-Hispanic and White.
- 'Hispanic' refers to persons of Spanish Origin who may be of any race, i.e., White, Black or other races.

In addition to these commonly understood definitions, the term 'racial minority' is used where selected data such as life expectancy statistics was not available separately for the Hispanic population. In such cases, data was available and is presented by race only, i.e., for the White, Black and other non-White populations. The obviously awkward term 'racial minority' is used to recognize that the minority population being described includes only Black and Hispanic non-White populations but not the Hispanic White ethnic minority.

The earlier chapters in this report present data from several sources in an examination of the growth and causes of growth being experienced by the minority elderly population.

Chapter 1 describes the size and diversity of the minority elderly population as reported in the 1980 Census, and the size of the 1985 study population which is profiled in later chapters based on data from the U.S.Bureau of the Census's Current Population Survey.

Chapter 2 is devoted to examining the recent dramatic growth in the number of minority elderly New Yorkers, and the projected growth of this population through the year 2000. Both the recent and extrapolated growth trends

presented in this chapter are based on an analysis of data from the Current Population Surveys conducted by the Bureau of the Census for the years 1981 through 1984.

Chapter 3 then examines the causes of the growth in the minority elderly population using statistics from the 1980 Census and earlier, migration statistics from the 1985 Current Population Survey, and life expectancy and mortality statistics from the National Center for Health Statistics.

In chapters 4 through 9, the report focuses on the current social and economic status of the minority elderly of New York State. The 1985 study population is the subject of these chapters and is defined as the minority elderly household population of the State in 1985. All descriptions of the study population are based on data for New York State collected by the U.S.Bureau of the Census in the March 1985 Current Population Survey (CPS).

The presentations in these chapters necessarily reflect the limitations inherent in data from the Current Population Survey. The CPS is an annual survey based on a probability sample representative of the non-institutional population. Collected through personal and telephone interviews, CPS data is subject to sampling variability which limits its use and interpretation (see Appendix B). Population "counts" from the CPS are based on a sample rather than a full enumeration and therefore are referred to as "estimates" throughout this report. While the CPS collects and reports data on the "non-institutional" population, all CPS data presented in this report is for the household population of New York State, exclusive of persons living in group quarters such as congregate homes as well as institutions such as nursing homes.

Chapter 4 presents a profile of selected socio-demographic charateristics of the minority study population, and is followed in chapter 5 by a description of current housing characteristics.

Chapters 6 through 9 focus on the economic status of minority elderly New Yorkers. They present an economic profile describing, in turn, the employment status, personal income, sources of income, and poverty and income status of the study population.

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Footnotes are used liberally throughout the chapter presentations to expand on statements and provide technical information. "Chapter Footnotes" may be found immediately following chapter 9, and preceeding "DETAILED TABLES."

The "DETAILED TABLES" section is a compilation of tables presenting all data discussed in this report and shown in the charts, and additional detail which may be useful for reference purposes. The section begins with a list of tables, and a "Chart and Table Cross-Index" to aid in locating data associated with each chart.

Appendices provide definitions from the CPS (Appendix A), a discussion of sampling error and convensions (Appendix B), poverty thresholds used in the 1985 CPS (Appendix C), preliminary minority elderly population estimates from the 1986 CPS (Appendix D), and 1985 CPS data on recipiency under selected public programs (Appendix E).

1. The Population In 1980 and 1985

There were close to 3 million persons aged 60 or older in New York State in 1980 and more than one out of every eight were minority elderly. Representing a major segment of the elderly population as a whole, the minority elderly further represented a diversity in cultural heritage and national origins only partially reflected in population statistics.

This chapter presents data from the 1980 Census[2] on the size of the minority elderly population of New York State, and on some the many sub-populations represented. It also introduces recent population estimates from the Current Population Survey (CPS) describing the study population which will be focus of the social and economic profiles presented in later chapters.

MINORITY ELDERLY POPULATIONS IN 1980

The 1980 Census reported 392,000 minority elderly (aged 60-plus) persons in New York State. They constituted 13 percent of a total elderly population of close to 3 million persons.

The Black and Hispanic aged were the two largest minority groups and, according to the '80 Census, accounted for nine out of every ten (90 percent)

Chart 1. Minority Elderly Population (Aged 60+)
of New York State -- 1980 CENSUS

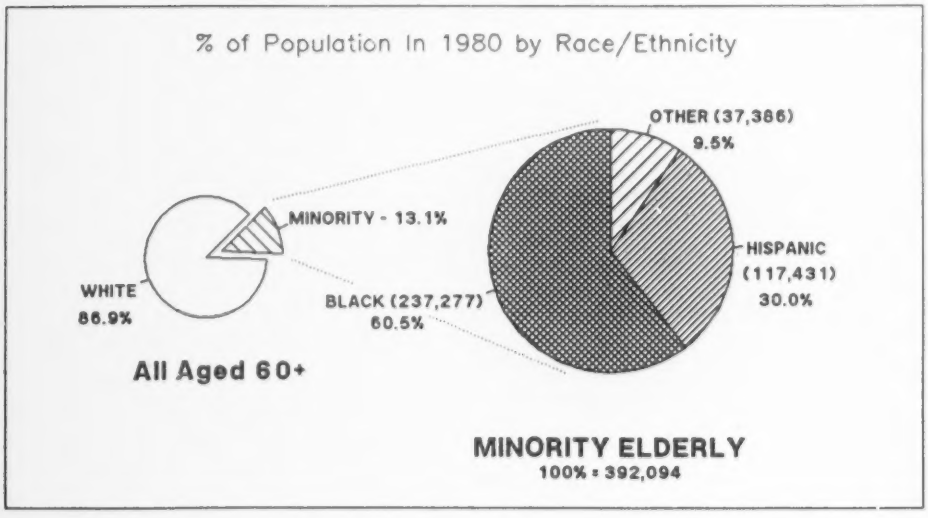
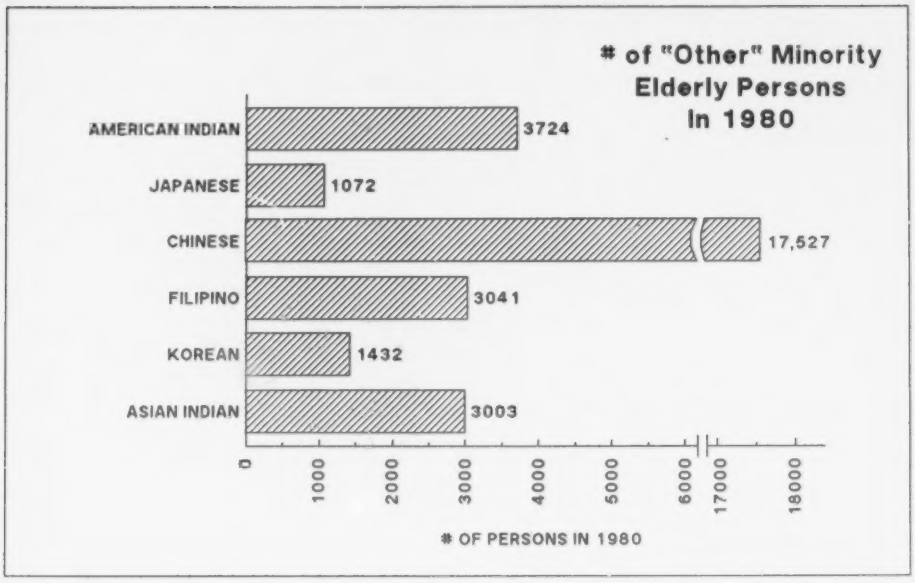


Chart 2. Selected "OTHER" MINORITY ELDERLY Populations of New York State -- 1980 CENSUS



of all minority elderly persons in the State. Of the total reported minority elderly population in 1980:

- o The Black aged numbered 237,000--more than 60 percent of all the minority elderly and 8 percent of the elderly population as a whole.
- o The Hispanic aged numbered 117,000--representing 30 percent of the minority elderly and 4 percent of all elderly persons in the State.
- o Aged Asian, Pacific Islander, American Indian and other racial minorities numbered 37,000--including over 17,000 Chinese aged as well as reported American Indian, Filipino and Asian Indian elderly populations of over 3,000 each.

THE 1985 STUDY POPULATION

The primary focus of much of this report is the social and economic status of the minority elderly household population of New York State in 1985. Of the minority elderly, the report presents findings specifically for the Black and Hispanic aged. The limitations inherent in the source of data prohibited analyses specific to other minority elderly groups (see Appendix B).

In 1985 an estimated 474,439 minority elderly persons were living in households in New York State. This compares to the 1980 Census enumeration of 392,094 minority elderly persons inclusive of institutional and other group quarter populations.[3]

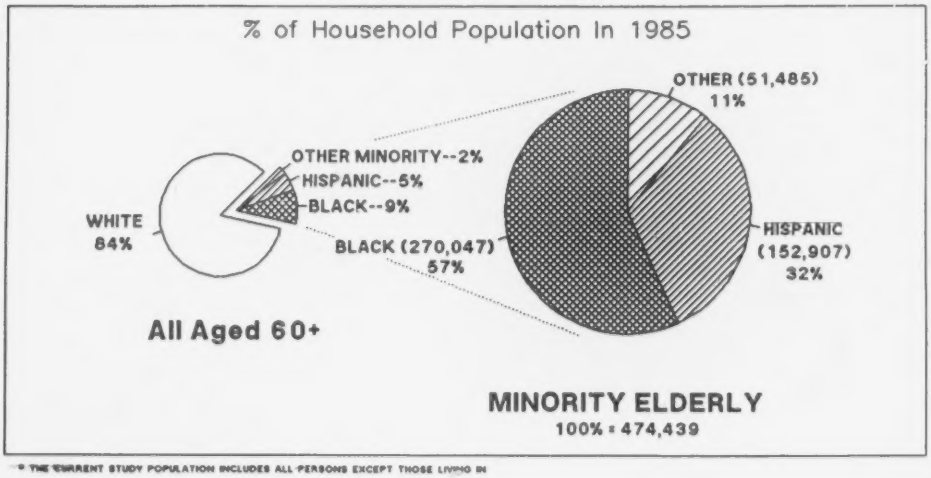
Of the 474,439 minority elderly persons in the study population[4]:

- o An estimated 270,047 or 57 percent were Black aged.
- o An estimated 152,907 or 32 percent were Hispanic aged.
- o An estimated 51,485 or 11 percent were other minority aged including Native Americans, Asians, and Pacific Islanders.

The total elderly (aged 60-plus) household population numbered an estimated 2,959,697 in 1985. Of this population:

- o One out of every six, or 16 percent were minority elderly persons;
- o Nine (9) percent were Black aged; and,
- o Five (5) percent were Hispanic aged.

Chart 3. Minority Elderly HOUSEHOLD POPULATION*
of New York State -- 1985 CPS



* THE CURRENT STUDY POPULATION INCLUDES ALL PERSONS EXCEPT THOSE LIVING IN INSTITUTIONAL SETTINGS AND OTHER GROUP QUARTERS.

2. Growth of the Population

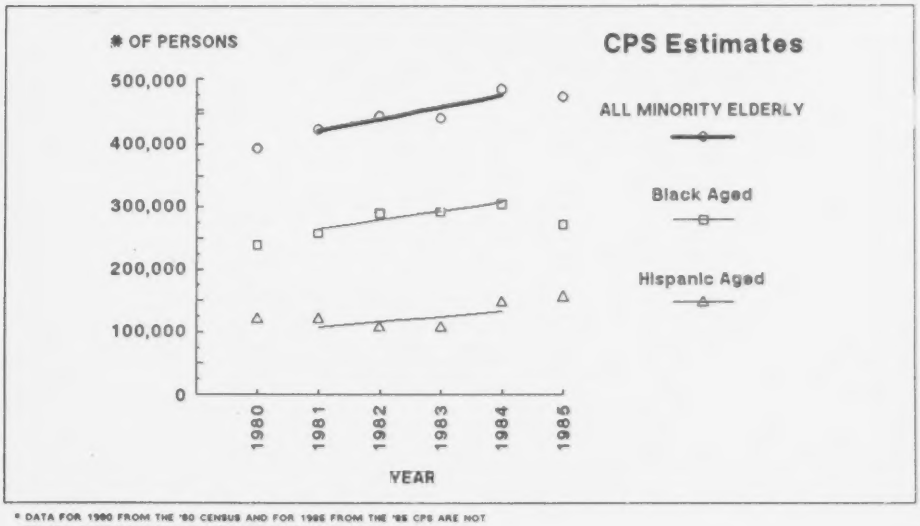
The minority elderly population is growing rapidly, and much faster than the rest of aged 60-plus population of the State. As the number of minority elderly New Yorkers increases dramatically, other segments of the elderly population are growing slowly or declining in size. This trend may be expected to continue through the year 2000. As it does, it will continue to alter the demographics of aging in New York State, and the basic social and economic characteristics of the general population of elderly New Yorkers.

This chapter describes the growth of the minority elderly household population during the 1980's. Data from annual Current Population Surveys beginning in 1981 are used to establish population trend lines for the minority elderly and, separately, for the Black and Hispanic aged as well. These trend lines are then projected through the year 2000 and show the effects of continued growth on the size of the minority elderly population as well as the composition of the total elderly population.

GROWTH SINCE 1981

The annual Current Population Survey for the years since the 1980 Census show a strong pattern of growth in the minority elderly population of the

Chart 4. CURRENT POPULATION SURVEY (CPS) ESTIMATES
of the Minority Elderly Household Population of New York State -- 1981 to 1984*



* DATA FOR 1980 FROM THE '80 CENSUS AND FOR 1985 FROM THE '85 CPS ARE NOT STRICTLY COMPARABLE TO CPS DATA FOR 1981 THROUGH 1984.

State. This trend is unmistakable as both the number of Black and Hispanic aged, as well as the total number of minority elderly increased.[5]

Between 1981 and 1984, CPS population estimates[6] show the average rate of growth for the minority elderly was 5 percent annually--an average increase of over 21,000 minority elderly persons a year for the three years. Separately[7], the CPS data shows an average rate of growth of:

- o 6 percent annually for the Black aged--an average increase of almost 16,000 persons a year between 1981 and 1984; and,
- o 9 percent annually for the Hispanic aged--an average increase of approximately 9,000 persons a year during the three year period.

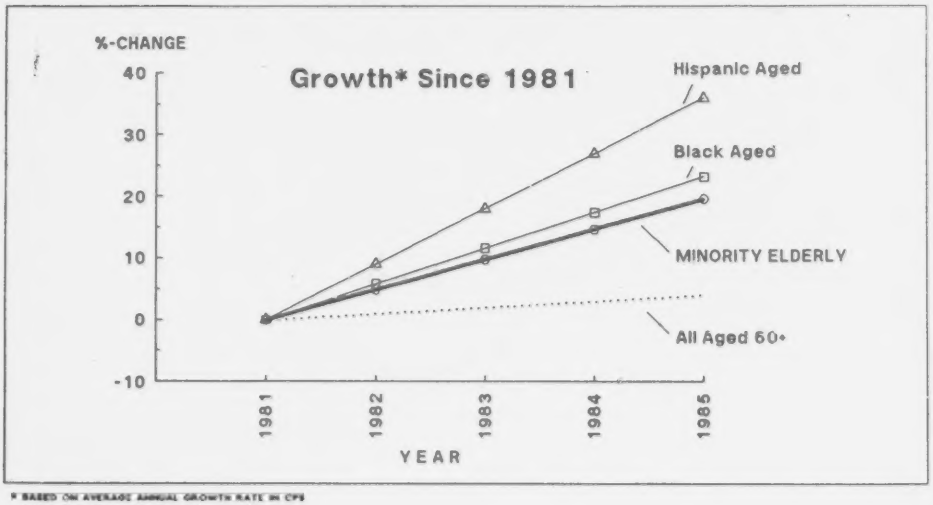
By 1985 the number of minority elderly had increased[8] to the current study population estimate of 474,439 minority elderly New Yorkers, including 270,047 Black aged and 152,907 Hispanic aged.

In comparison, the non-minority elderly population remained stable at approximately 2.6 million from 1981 to 1984, and the total elderly population grew at an average rate of 1 percent a year.

PROJECTED GROWTH TO THE YEAR 2000

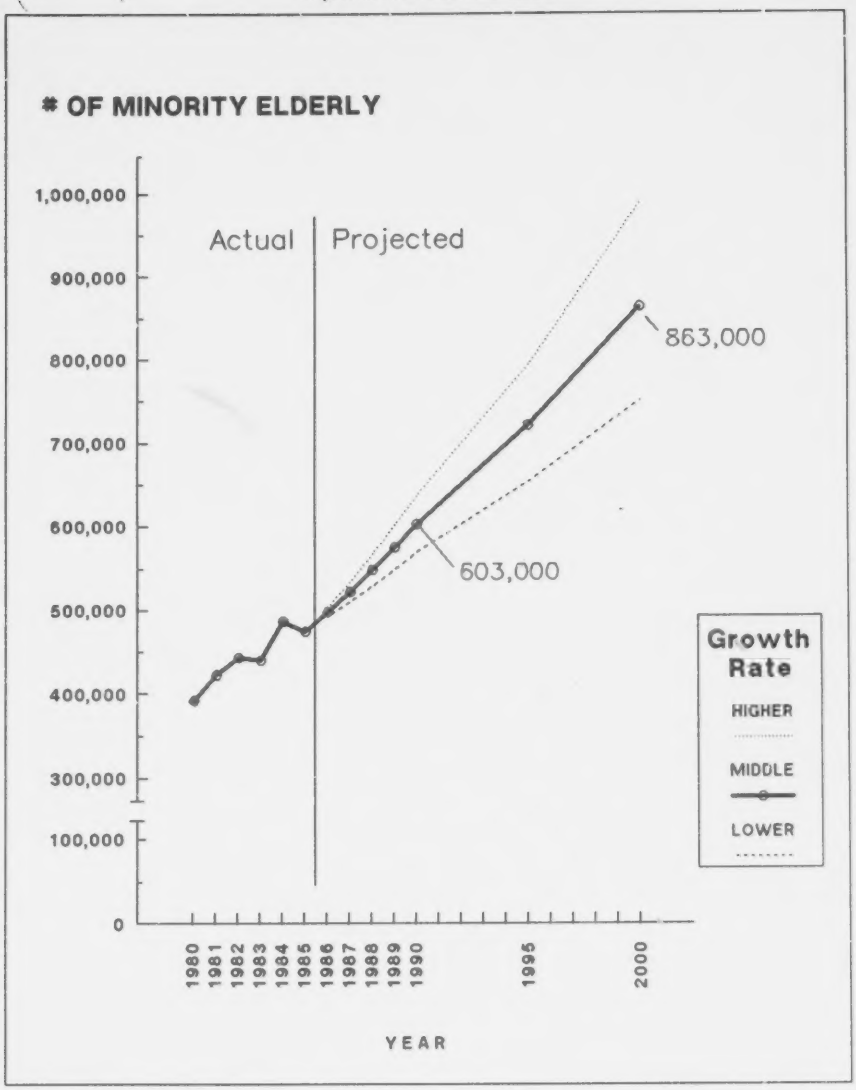
As the number of minority elderly New Yorkers increases rapidly, the total elderly population is expected to reflect this growth in modest increases; and, the non-minority elderly population may experience some decline. The younger non-minority cohorts are expected to decrease in size prior to the

Chart 5. CUMULATIVE RATE OF GROWTH*
In the Minority Elderly Population From 1981 Thru 1985



* BASED ON AVERAGE ANNUAL GROWTH RATE IN CPS POPULATION ESTIMATES FOR 1981 THROUGH 1984.

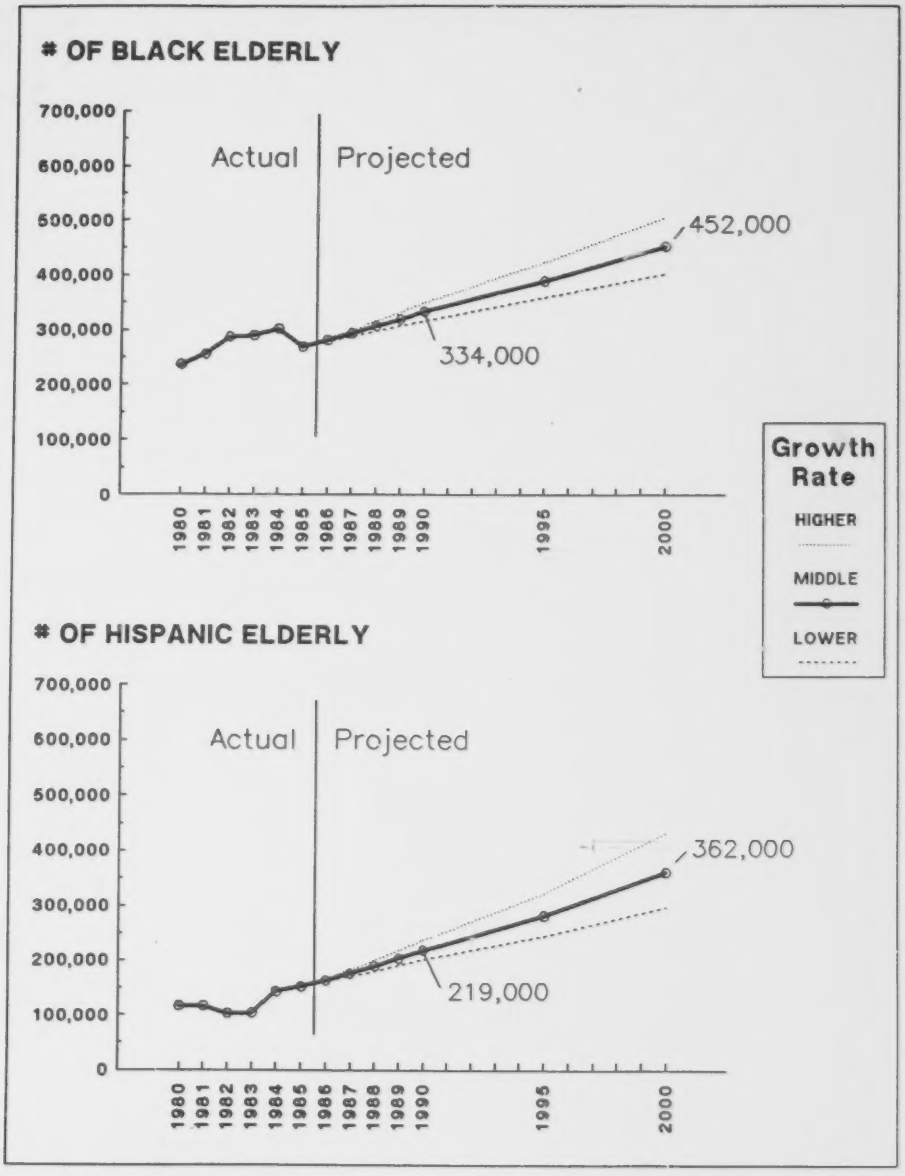
Chart 6A. Projections* of the MINORITY ELDERLY Population to the Year 2000



* LINEAR "STRAIGHT LINE" PROJECTIONS BASED ON THE AVERAGE ANNUAL GROWTH IN CPS POPULATION ESTIMATES FOR 1981 THROUGH 1984.

NOTE: LOWER AND HIGHER GROWTH RATES ASSUME 75% AND 125% OF THE AVERAGE ANNUAL GROWTH RATE FROM 1981 THROUGH 1984, RESPECTIVELY.

Chart 6B. Projections* of the BLACK and HISPANIC Elderly Populations to the Year 2000



* LINEAR "STRAIGHT LINE" PROJECTIONS BASED ON THE AVERAGE ANNUAL GROWTH IN CPS POPULATION ESTIMATES FOR 1981 THROUGH 1984.

NOTE: LOWER AND HIGHER GROWTH RATES ASSUME 75% AND 125% OF THE AVERAGE ANNUAL GROWTH RATE FROM 1981 THROUGH 1984, RESPECTIVELY

year 2000 and the ensuing "senior boom." Until then, the minority elderly and the older aged 75-plus non-minority populations will continue to comprise an ever increasing part of the State's total elderly population.[9]

Minority elderly population projections can be expected to follow the high growth trend evident since 1981 through the year 2000. In the short term, continued growth can be expected through 1990 at the same annual average rates. Between 1990 and 2000, some moderation of these growth rates can be expected (see the discussion of "aging-in" in the next chapter). Projections based on lower, moderate and higher rates establish a reasonable range of alternative growth assumptions.

Such "straight line" extrapolations[10] of the growth which has occurred since 1981, show that the current 1985 study population of the minority elderly will, by 1990:

- o Increase by 27 percent to number 603,000 and comprise 19 percent of all elderly New Yorkers;
- o Include a Black aged population numbering 334,000 and comprising 11 percent of the entire elderly population--a projected 24 percent increase from 1985 and 41 percent increase since the 1980 Census; and,
- o Include a Hispanic aged population numbering 219,000 and comprising 7 percent of the entire elderly population--a projected 43 percent increase from 1985 alone, and a dramatic 86 percent increase since the 1980 Census.

Assuming a moderation of this trend after 1990, the minority elderly population is projected (see charts for "higher" and "lower" rate projections) by the year 2000 to:

- o Number 863,000 persons and comprise more than 1-in-4--or over 25 percent--of the State's total aged 60-plus population;
- o Include 452,000 Black aged who will account for more than 1-in-8, or 13 percent of the elderly; and,
- o Include 362,000 Hispanic elderly persons who will account for close 1-in-9, or 11 percent of all older New Yorkers.

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3. Causes of Population Change

The growth in the minority elderly population of New York State is due to the combined affects of three phenomena--the aging of younger cohorts into the 60-plus population, migration into New York State, and to a lesser extent, changes in life expectancy.

Younger cohorts in the State's minority population which experienced major population growth in past years, are now reaching 60 years of age and swelling the ranks of the minority elderly. Also, the minority elderly population of the State is expanding as older minority persons move to New York from other states and abroad.

Changes in life expectancy are further adding to the increasing numbers of the minority elderly, primarily due to declining mortality rates in the under 60 population. Increases in the life expectancy of the minority elderly have been small, and have had little impact on either population growth or lengthening the life expectancy of the minority elderly to that of the rest of the elderly population.

This chapter examines each of these trends using a variety of data sources. In many cases the discussion is limited to the racial minority elderly (i.e., Black and other "non-White") due to the absence of separate statistics on the Hispanic aged. The lack of availability Hispanic data is critical, particularly to the discussion of life expectancy. Life expectancy is examined by race, together with leading causes of death, and is not only a cause of population change, but a major indicator of health and quality of life.

AGING-IN OF YOUNGER COHORTS

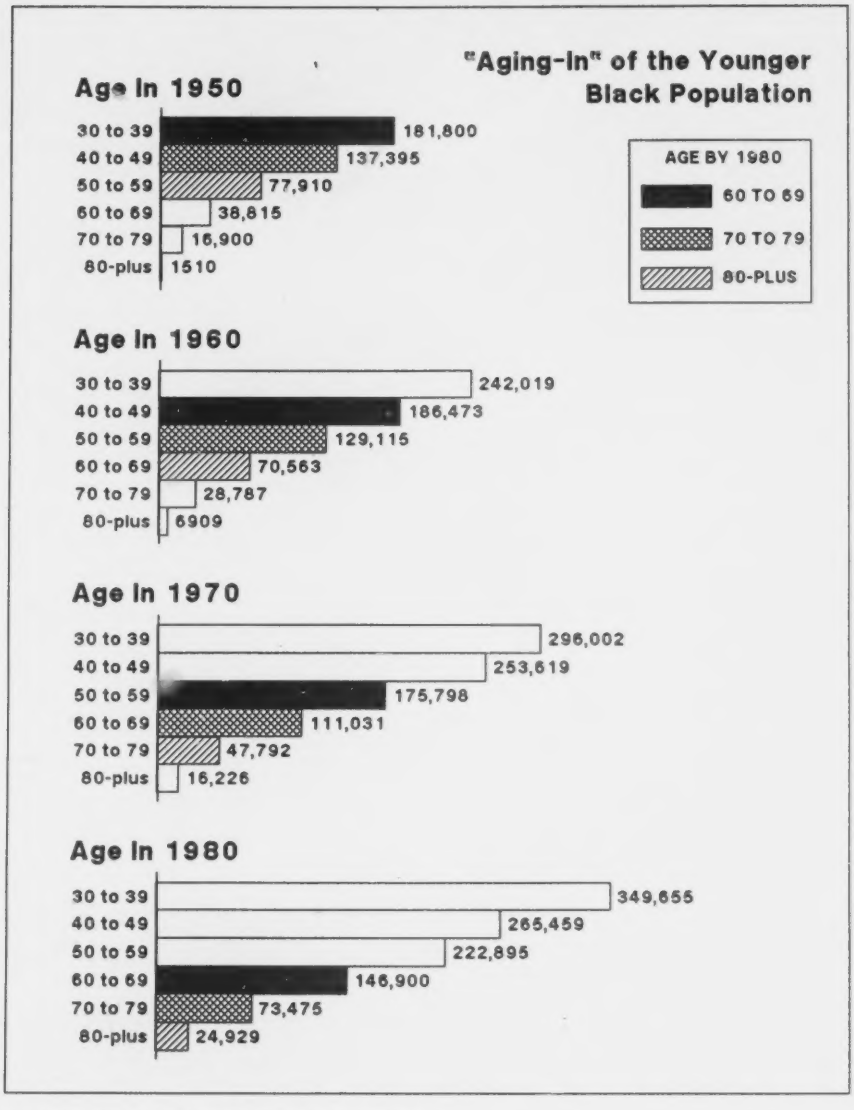
The minority populations of New York State reflect, more than others, historical migration to New York from other states and nations. During the 1960's and early 1970's net in-migration swelled the ranks of younger minority cohorts as the socio-economic conditions of the State drew families from across the nation, and as the Port of New York kept its arms open to immigrants from other nations.

By 1970, the age structure of the minority population, as reflected in data available for the Black population[11], showed large mid-life and pre-elderly age cohorts which are now contributing to today's growth of the minority elderly. As reported in the 1970 Census by race[12]:

- The Black "mid-life" cohort (aged 40-to-49) numbered over 253,000--36 percent and 67,000 more than they numbered just ten years earlier in 1960.

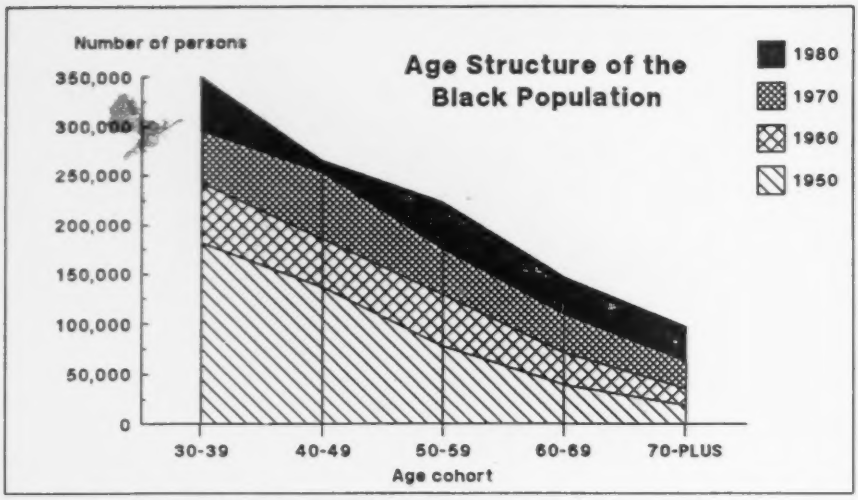
- The Black "pre-elderly" cohort (aged 50-to-59) numbered over 175,000--again 36 percent and 46,000 more than they had numbered in 1960.

Chart 7. AGING of MID-LIFE and PRE-ELDERLY Cohorts into the Older Black Population: Black Population of New York State by Age, 1950 to 1980



DATA SOURCE: 1980, 1960, 1970, AND 1980 CENSUSES OF THE POPULATION.

Chart 8. AGE STRUCTURE of the BLACK POPULATION
of New York State in 1950, 1960, 1970 and 1980



DATA SOURCE: 1950, 1960, 1970, AND 1980 CENSUSES OF THE POPULATION.

Between 1970 and 1980 each of these cohorts grew ten years older. The "mid-life" cohort of 1970 became the "pre-elderly" cohort of 1980, as the "pre-elderly" cohort aged-in and became the "younger elderly" (aged 60-to-69).

By 1980, as reported in the '80 Census by race[12]:

- The Black "younger elderly" cohort numbered close to 147,000--32 percent and 36,000 more than they had numbered in 1970 as the larger "pre-elderly" cohort entered their ranks.

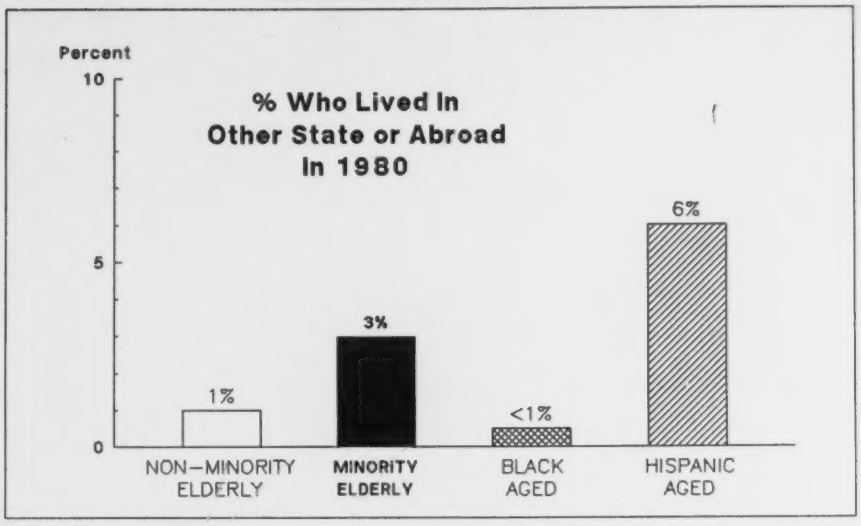
- The Black "older elderly" (aged 70-plus), due in part to the aging-in of the larger "mid-life" and "pre-elderly" cohorts of the 1950's and 1960's, numbered over 98,000--an increase of 54 percent and more than 34,000 since 1970.

Over the same period, the larger "mid-life" cohort of 1970 expanded the ranks of the 1980 "pre-elderly" cohort. It is this cohort that is now turning 60 or older, and contributing to the continued dramatic growth of the minority elderly population. As reported in the 1980 Census:

- The Black "pre-elderly" cohort numbered close to 223,000--an increase of 27 percent or 47,000 since 1970, in part due to the influx of the larger 1970 "mid-life" cohort.

This "aging-in" phenomenum is expected to continue to contribute to the rapid growth projected through 1990 and, with some moderation, through the year 2000. Growth from aging-in, while remaining significant, is expected to moderate in the 1990's due to a net out-migration of younger workers and

Chart 9. Percentage of the Minority Population That MOVED TO NEW YORK STATE Between 1980 and 1985 ('85 CPS)



families in the late 1970's and early 1980's to the "sunbelt" states. This counter trend will dampen the effects of aging-in and contribute to the more moderate growth rates reflected in projections for the coming decade.

MIGRATION

Recent migration of minority elderly persons into New York State is also contributing to the population's rapid growth. The minority elderly are much more likely than the non-minority elderly to have moved during the past five years, and to have migrated to New York State from other states and abroad.

Of the study population (see chapter one), 3 percent of the minority elderly in 1985--in comparison to only 1 percent of the rest of the elderly--had lived in a different state or abroad, and moved to New York State in the past five years.

While these total figures are small[13], they include sharply contrasting patterns in the migration of different minority elderly populations:

- o Less than 1 percent of all Black aged in 1985 had moved to New York State since 1980.
- o Approximately 10,000 or over 6 percent of the Hispanic aged moved to New York State within the last five years.
- o A total of 14,000 of the Hispanic and "other" minority elderly combined, had come from other states or abroad to live in New York State in 1985.

LIFE EXPECTANCY AND LEADING CAUSES OF DEATH

Changes in life expectancy are the third factor currently contributing to the growth of the minority elderly in New York State. However, the implications of life expectancy statistics extend to the health and quality of life experienced by the minority elderly.

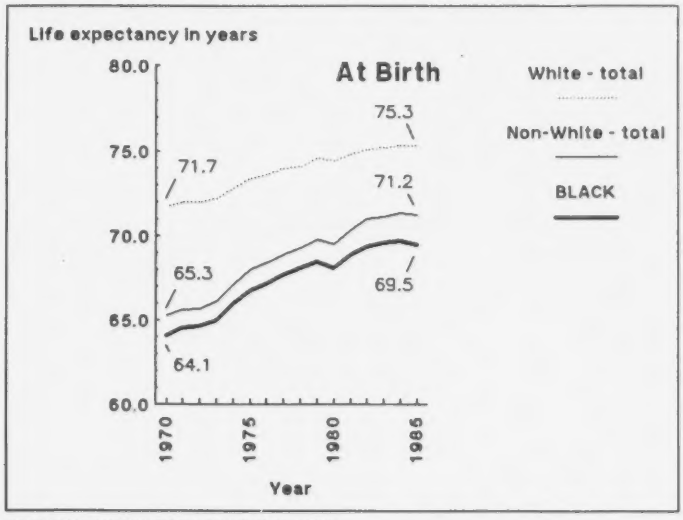
The life expectancy of a population or cohort is one of the most valid and widely recognized indicators of its health status. The members of any population suffering high mortality rates from disease, environmental conditions, or poor health care, will have a shortened life expectancy. Shorter or longer life expectancies are a direct indicator of a population's comparative risk of dying.

Vital statistics reported for the United States show that members of racial minority populations[14] are increasingly likely to live to be elderly, and once they grow old, to live longer.

Since 1970 life expectancy AT BIRTH has:

- Increased 6.0 years for all minority races combined--from 65.3 years to 71.3 years in 1983;
- Increased 5.6 years for the Black population--from 64.1 years to 69.7 years in 1983; and in comparison,
- Increased only 3.5 years for the White population, but from 71.7 years to 75.2 years in 1983.

Chart 10A. LIFE EXPECTANCY AT BIRTH by Race, 1970 thru 1985 -- United States



DATA SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS.

Over the same period, life expectancy AT AGE 65 also increased but the increases did not reduce the gap between the life expectancy of minority and White races. Since 1970, expectation of life at age 65 increased 1.3 years for all minority races, and in comparison, increased 1.6 years for the White population by 1983.

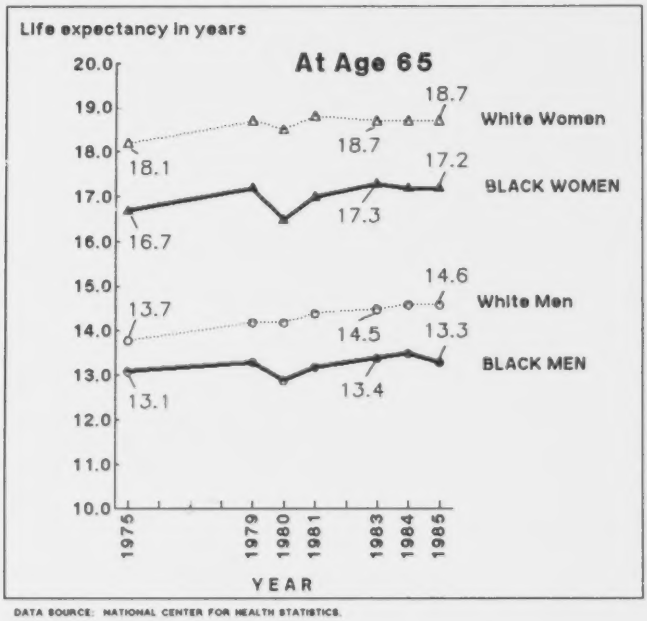
These increases in life expectancy, particularly at younger ages, have contributed to the growth of the minority elderly, but perhaps little more than they have affected the non-minority elderly population. Just as important in their own right, however, are the persistent differences which continue to exist at older ages.

Minority races continue to have a shorter life expectancy at age 65, and older men of all races continue to have a much shorter life expectancy than older women.

In 1983 expectation of life at age 65 was:

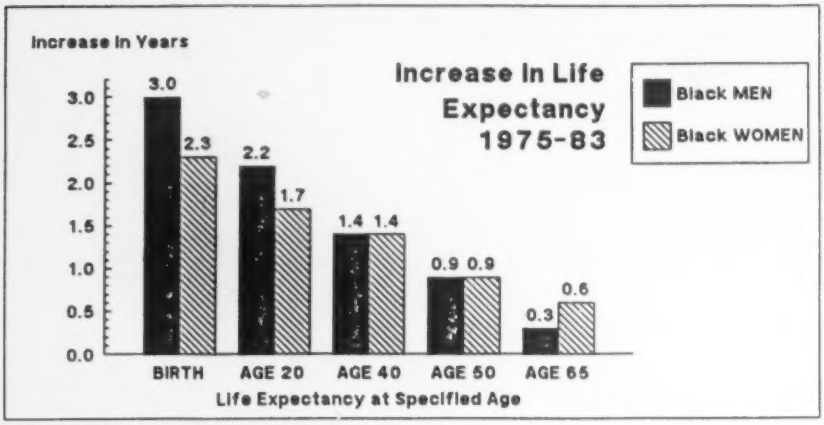
- o 16.2 years for all minority races--including 14.1 and 17.9 years for men and women respectively;
- o 15.5 years for the Black population--including 13.4 and 17.3 years for men and women respectively; and in comparison,
- o 16.8 years for the White population--including 14.5 and 18.7 years for men and women respectively.

Chart 10B. Life Expectancy of BLACK MEN and WOMEN at AGE 65 -- United States



DATA SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS.

Chart 11. CHANGE IN YEARS of Life Expectancy of BLACK MEN and WOMEN at Different Ages -- United States, Change from 1975 to 1983



DATA SOURCE: NATIONAL CENTER FOR HEALTH STATISTICS

The differences reflected in these figures are considerably less at older ages. For example, life expectancy at age 85 is between 5.2 and 7.5 years for men and women of all races, respectively.

Conversely, larger differences exist at younger ages and are much more significant in shaping the composition of the minority elderly population in terms of both age and sex. Life expectancy at age 60 in 1983 was:

- o 18.4 years for the Black population--in comparison to 20.4 years for the White population;
- o 16.0 years for Black men--in comparison to 17.9 years for White men; and,
- o 20.5 years for Black women--in comparison to 22.6 years for White women.

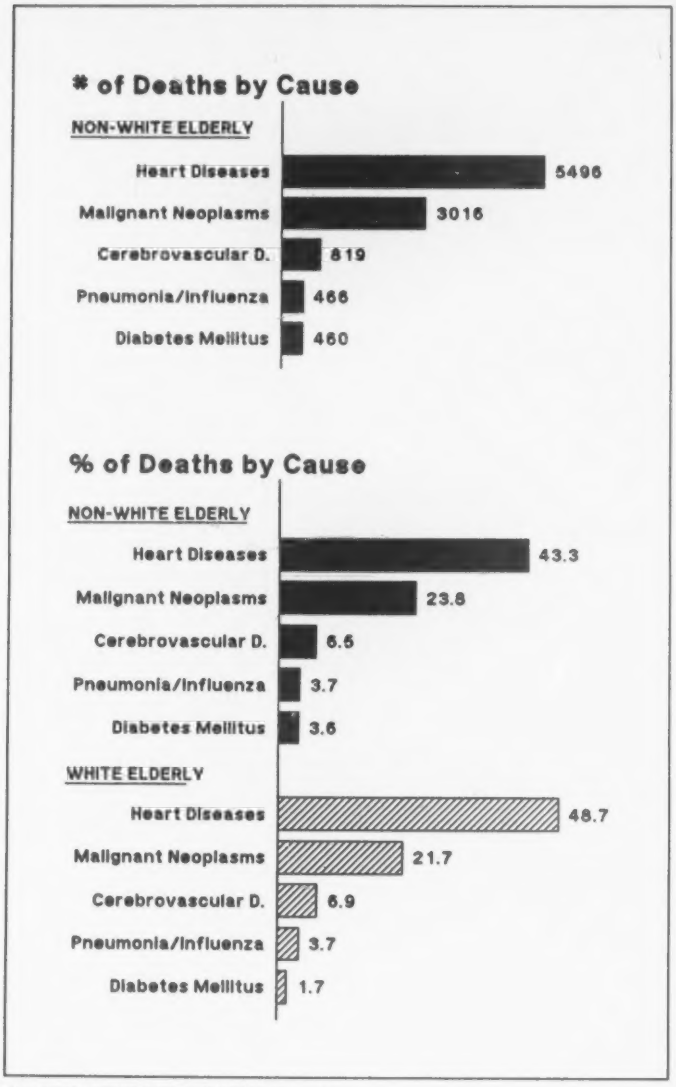
At age 60, as these figures show, the Black population has a consistently two year shorter life expectancy than the White population; and, Black men have a four and a half year shorter life expectancy than Black women.

These figures also show that the life expectancy of Black men at age 60 is almost 30 percent less and 7 years shorter than that of White women.

The shorter life expectancies of the minority elderly are a direct reflection of their higher mortality rates at younger ages. However, the leading causes of death among the minority and non-minority elderly are the same.

According to the records of the New York State Department of Health[15], 133,186 elderly New Yorkers (aged 60-plus) died in 1984 including 12,693 racial minority elderly. Of these deaths, the same five causes accounted for

Chart 12. LEADING CAUSES OF DEATH of "NON-WHITE" Minority Elderly (Aged 60+) by Race in 1984 -- New York State



DATA SOURCE: NEW YORK STATE DEPARTMENT OF HEALTH.

81 percent of the deaths of racial minority elderly persons as accounted for 83 percent of the deaths of White elderly persons.

Heart disease was by far the leading cause of death for the minority elderly, with cancer (i.e., malignant neoplasms) by far the second leading cause:

- o 43.3 percent of all minority elderly deaths were due to heart disease--in comparison to 48.7 percent of all White elderly deaths;
- o 23.8 percent were due to cancer--in comparison to 21.7 percent;
- o 6.5 percent were due to cerebrovascular disease--in comparison to 6.9 percent;
- o 3.7 percent were due to pneumonia and influenza--in comparison to an equal percent; and,
- o 3.6 percent were due to diabetes mellitus--in comparison to 1.7 percent.

While differences do exist (i.e., a slightly higher proportion of minority elderly deaths was due to cancer and diabetes, and lower proportion due to heart disease), the minority and non-minority elderly generally die from the same causes.

The minority elderly however die younger, as shown by their shorter life expectancies, either from the earlier onset of, or a greater likelihood of death from, the same illnesses and conditions that afflict the non-minority elderly.

Limited access to health care, delay in seeking or inability to seek medical assistance, disadvantaged social and economic conditions that cause stress and illness, inadequate preventative and health education services, and a basic lack of money may contribute, if not cause the shorter life expectancy of the minority elderly.

4. Socio-Demographic Characteristics

The socio-demographic composition of today's minority elderly population has been shaped by the factors underlying recent population growth and, more deeply, by the historic lack of opportunity to fully participate in the mainstream of American society.

The age and sex structure of the minority elderly population strongly reflects the shorter life expectancies of the minority elderly and men. At the same time, differences in in-migration and "aging-in" are reflected in differences in the age and sex of the Black and Hispanic elderly populations.

The formal education, marital status and current living arrangements of the minority elderly also reflect differences in life expectancy and in-migration, but more importantly, the social and economic conditions that place stress on the minority family unit and that have limited minority opportunities.

This chapter describes the composition of the minority elderly study population in profiles of its age, sex, formal education, marital status and current living arrangements. Each profile is descriptive of minority elderly New Yorkers in 1985 based on data from the 1985 Current Population Survey.

AGE

The minority elderly population was younger than the rest of the State's elderly population in 1985. The population's shorter life expectancy continued to be reflected by the smaller proportion of minority elderly aged 75 and over. Perhaps reflecting recent in-migration patterns, the Hispanic aged was younger than the Black aged whose recent population growth has more clearly resulted from the aging-in of younger cohorts.

Of the 1985 study population:

- o A third or 32 percent of the minority elderly were 60 to 64 years old--in comparison to less than a third or 29 percent of the non-minority elderly.

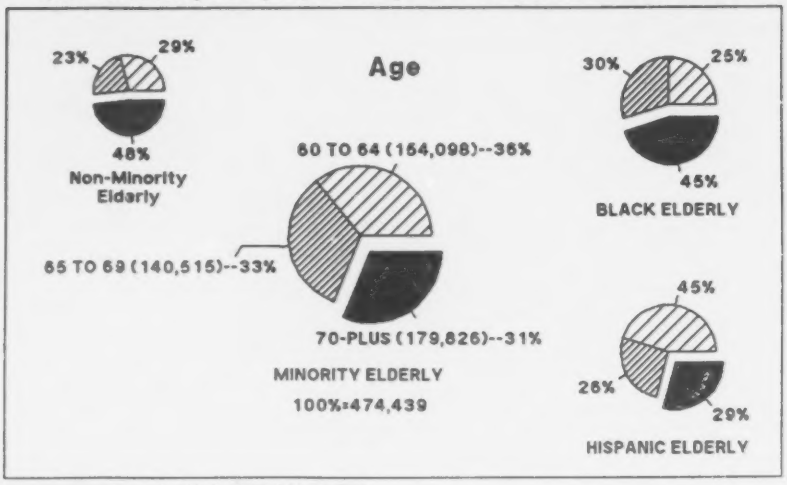
- o Nearly half or 46 percent of the minority elderly were 65 to 74 years old--in comparison to 42 percent of the non-minority elderly.

- o Fewer than one-in-four (or 22 percent) of the minority elderly were 75 years of age or older--in comparison to well over one-fourth (or 29 percent) of the non-minority elderly.

The Black aged were predominantly aged 65 to 74, while the largest group of Hispanic aged were aged 60 to 64:

- o Twenty-five (25) percent of the Black aged, but 45 percent of the Hispanic aged were 60 to 64 years old.

Chart 13. Minority Elderly Population by AGE in 1985, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

- o Fifty (50) percent of the Black aged, and a smaller 38 percent of the Hispanic aged were 65 to 74 years old.

- o Only 25 percent of the Black aged, and an even smaller 17 percent of the Hispanic aged were aged 75 and over.

SEX

The sex composition of the minority elderly population reflects the longer life expectancy of women which is such a predominant factor in determining many of the socio-economic characteristics of the elderly population as a whole.

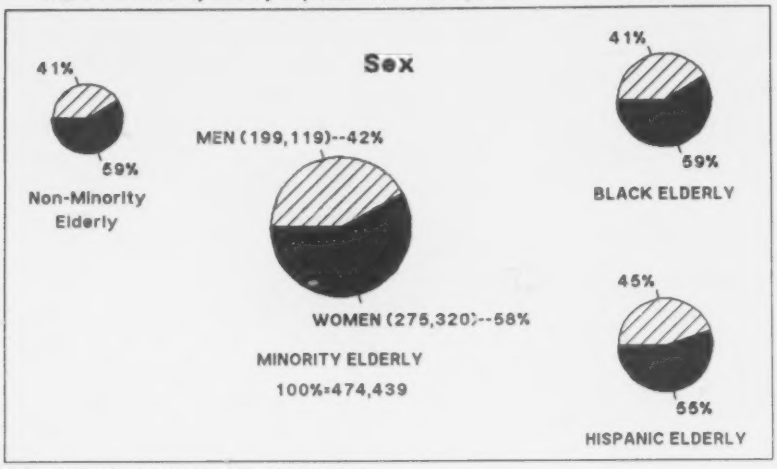
Women out-numbered men by almost three-to-two among both the minority and non-minority elderly. The Black aged, who were predominantly aged 65 to 74, had a similarly high ratio of women to men. The Hispanic aged, who were predominantly aged 60 to 64, had a lower ratio of women to men, i.e., a higher proportion of men.

In 1985 the ratio of women to men was:

- o 58 women to 42 men among the minority elderly, and a similar 59 women to 41 men among the non-minority elderly.

- o 59 women to 41 men among the Black aged, but a lower 55 women to 45 men among the Hispanic aged who were typically much younger.

Chart 14. Minority Elderly Population in 1985 by SEX, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

EDUCATION

Today's minority elderly neither have the past formal education of the rest of population, nor did they have the educational opportunities afforded others.

There is little doubt that for most of the minority elderly, past formal education is a direct indicator of the treatment minorities historically received in the educational systems of the United States. For some of the minority elderly who are recent immigrants, however, it is a culture bound indicator, tied to the educational system and amount of education afforded by their respective native countries.

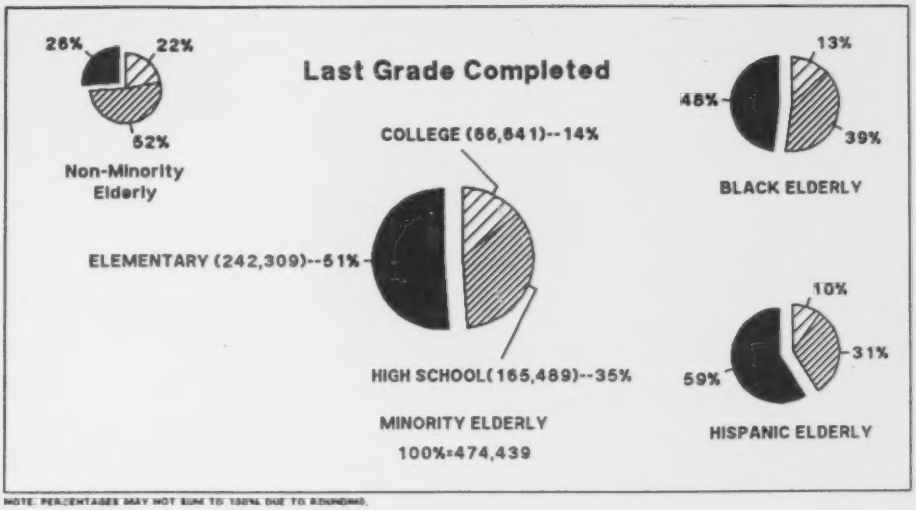
Of minority elderly New Yorkers in 1985:

- o Half (or 51 percent) never completed a school grade beyond elementary--in comparison to only 26 percent of the rest of the elderly population.
- o Conversely, half (or 49 percent) attended high school or college--in comparison to 74 percent of the non-minority elderly.
- o Only 14 percent attended college--in comparison to 22 percent of the non-minority elderly.

Relative to these major differences, the past formal education of the Black and Hispanic elderly were similar:

- o Forty-eight (48) percent of the Black aged, and 59 percent of the Hispanic aged had not completed a school grade beyond elementary.

Chart 15. Minority Elderly Population in 1985 by LAST SCHOOL GRADE COMPLETED, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

- o Thirty-nine (39) percent of the Black aged, and 31 percent of the Hispanic aged had attended high school.
- o Only 13 and 10 percent of the Black and Hispanic aged, respectively, had attended college.

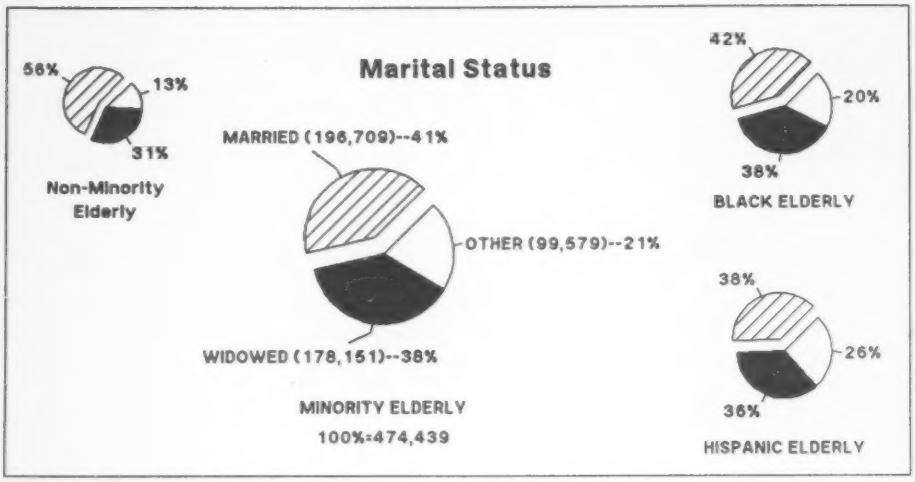
MARITAL STATUS

The marital status of the minority elderly reflects the population's shorter life expectancy, and like past formal education, is interwoven with the disadvantage of unequal opportunity. Poorer social and economic conditions place major stress on the minority nuclear family, and contribute to the break-up of the family which is reflected in the minority elderly's marital status.

Of minority elderly New Yorkers in 1985:

- o Twelve (12) percent were currently divorced or separated (including 10 and 20 percent of the Black and Hispanic aged respectively)--in comparison to only 4 percent of the non-minority elderly.
- o Although typically younger, 38 percent were widowed (including 38 and 36 percent of the Black and Hispanic aged respectively)--in comparison to only 31 percent of the generally older non-minority elderly.
- o An additional 9 percent had never been married (including 11 and 6 percent of the Black and Hispanic aged respectively)--in comparison to a similar 8 percent of the non-minority elderly.

Chart 16. Minority Elderly Population in 1985 by MARITAL STATUS, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

- o Forty-one (41) percent were currently married (including 42 and 38 percent of the Black and Hispanic aged respectively)--in comparison to well over half or 56 percent of the non-minority elderly.

LIVING ARRANGEMENTS

The living arrangements of the minority elderly are most reflective of their high incidence of single-person marital status, whether widowed, divorced, separated or never married. Still many of the minority elderly live in extended family households of four or more members. They are often forced to do so by poverty, not only their own but that of their children or other household members with whom they live, or who may be living with them.

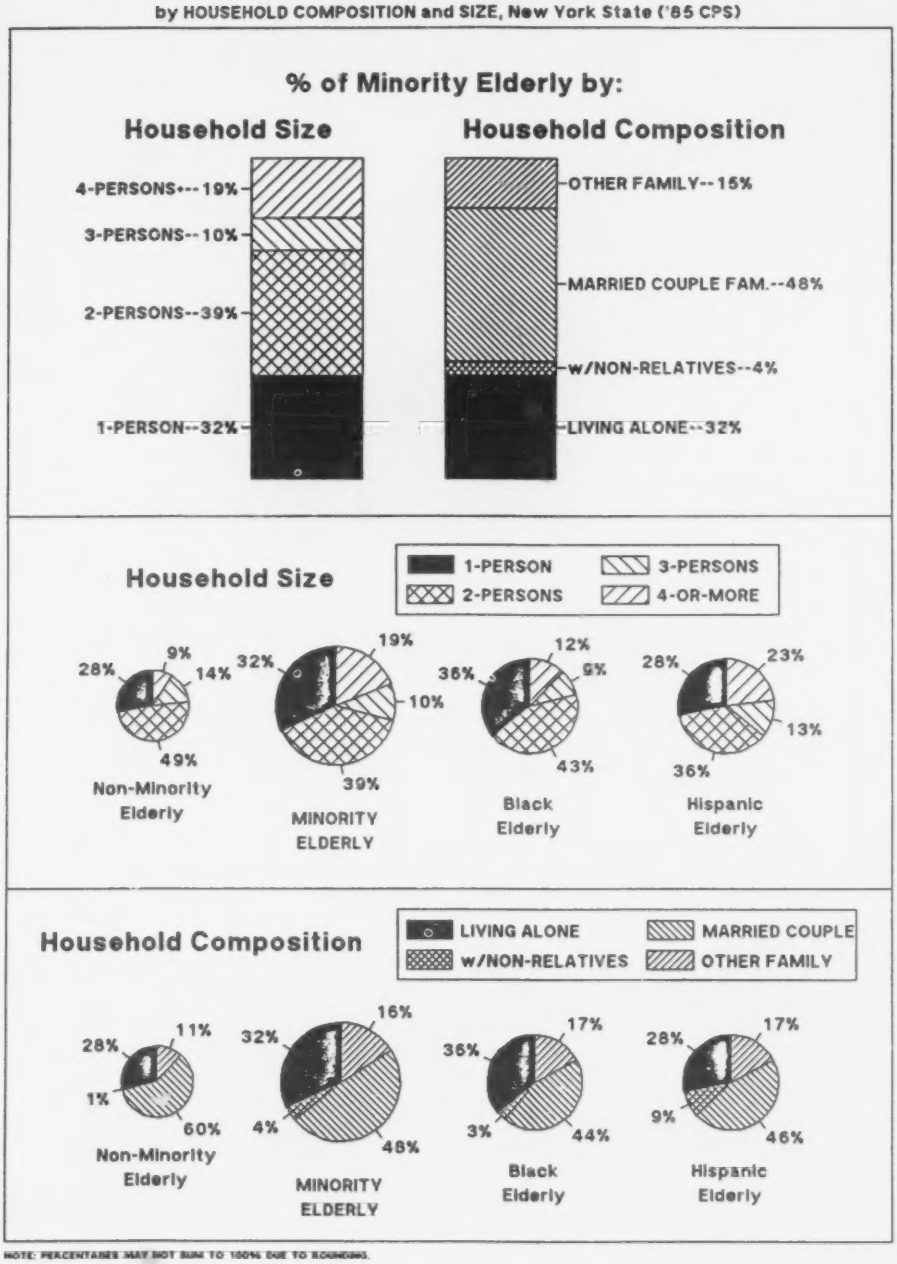
In 1985:

- o A third (or 32 percent) of the minority elderly lived alone, maintaining one-person households--in comparison to only 28 percent of the non-minority elderly.

- o Less than half (or 48 percent) lived in a married couple household either with their spouse or married family members--in comparison to well over half (or 60 percent) of the non-minority elderly.

- o A fifth (or 20 percent) lived in other types of household either with relatives (15 percent) or unrelated persons (under 5 percent)--in comparison to only 12 percent of the non-minority elderly who lived in such "other family" (11 percent) and "non-family" (1 percent) households.

Chart 17. Minority Elderly Population in 1985
by HOUSEHOLD COMPOSITION and SIZE, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

Of the minority elderly population:

- Thirty-six (36) percent of the Black aged, and 28 percent of the Hispanic aged lived alone in one-person households.

- Only 44 and 46 percent of the Black and Hispanic aged, respectively, lived in married couple households.

- An additional 17 percent, or more than one-in-six of both the Black and Hispanic aged lived with relatives in "other family" households.

- A small proportion (3 percent) of the Black aged, but almost one-in-ten (or 9 percent) of the Hispanic aged lived with unrelated persons in other "non-family" households.

The minority elderly were typically living in one or two-person households, yet accounted for a disproportional 29 percent of all elderly persons living in households with four-or-more members. In comparison to the non-minority elderly, they were not only more likely to be living alone but more likely to be living with at least three other people:

- Thirty-two (32) percent of the minority elderly lived alone in one-person households (including 36 and 28 percent of the Black and Hispanic aged respectively)--in comparison to 28 percent of the non-minority elderly.

- Thirty-nine (39) percent of the minority elderly lived in two-person households (including 43 and 36 percent of the Black and Hispanic aged respectively)--in comparison to 49 percent of the non-minority elderly.

- Only 10 percent of the minority elderly lived in three-person households (including 9 and 13 percent of the Black and Hispanic aged respectively)--in comparison to 14 percent of the non-minority elderly.

- One-in-five or 19 percent of the minority elderly lived with at least three other persons in households with four-or-more members (including 12 and 23 percent of the Black and Hispanic aged respectively)--in comparison to only 9 percent of the non-minority elderly.

5. Housing Characteristics

One of the most basic facts concerning the minority elderly population is the very high concentration of their residences in the central cities of the State. An overwhelming number of the minority elderly have their residences in New York City alone.

This single fact affects many of the housing characteristics of the minority elderly, and may also account, in part, for a greater mobility among the minority elderly in moving from one residence to another. Not only are the minority elderly predominantly renters, as is typical of urban residents, but they often live in larger multi-unit apartment buildings. Because of low income, the minority elderly are also more likely to be living in public housing and in housing units missing facilities taken for granted by most in today's society.

This chapter describes the location of the minority elderly in New York State in 1985, and presents racial minority elderly population estimates by county, recently released by the U.S.Bureau of the Census. It further describes the housing tenure of the minority elderly study population, along with the selected housing characteristics reported in the 1985 Current Population Survey.

GEOGRAPHIC LOCATION

In sharp contrast to the total elderly population, the minority elderly population is highly concentrated in selected urban areas of New York State. Most minority elderly persons live in New York City, and those who do not, are typically residents of the State's other central cities. This concentration of the minority elderly in so high that most areas of New York State have older populations which are comprised almost exclusively of the non-minority elderly.

In 1985 the geographic distribution of the total elderly population was similar to that of the State's general population. Approximately one-out-of-two elderly persons (or 47 percent) lived in the State's central cities, including 39 percent who lived in New York City. A little over half (or 53 percent) lived in other areas of the State, in suburbs, smaller cities and villages or open rural country.

In sharp contrast to this pattern:

- Four-out-of-five (or 81 percent) minority elderly persons lived in the State's central cities--including 75 and 89 percent of the Black and Hispanic elderly respectively.
- Three-out-of-four (or 74 percent) lived in New York City alone--including 65 percent of all Black and 88 percent all Hispanic elderly in the State.

- Only one-in-five (or 19 percent) lived in the extensive geographic area of the State outside central cities--including 25 percent of the Black elderly and only 11 percent of the Hispanic elderly.

The minority elderly constituted 30 percent of New York City's elderly population. In other central cities, minorities constituted 14 percent of all elderly persons. All but 6 percent or one-in-twenty of those in the rest of the State were non-minority elderly persons.[16]

These differences in the concentration of the minority elderly population are dramatically shown in recent estimates of the elderly populations of counties by race. Prepared by the U.S.Bureau of the Census[17], the estimates show that in 1984 the Black and other racial minority elderly comprised:

- Under 2 percent of the elderly persons living in thirty-seven of the State's sixty-two counties;
- From 2 percent to less than 5 percent of the elderly living in an additional seventeen counties;
- Five (5) percent or more of the elderly populations of only seven counties including the five counties (boroughs) of New York City; and,
- Ten (10) percent or more of the elderly in just four counties, all of which are boroughs of New York City--from 14 percent of the elderly population of Queens to over 28 percent of the elderly residing in the borough of Manhattan.

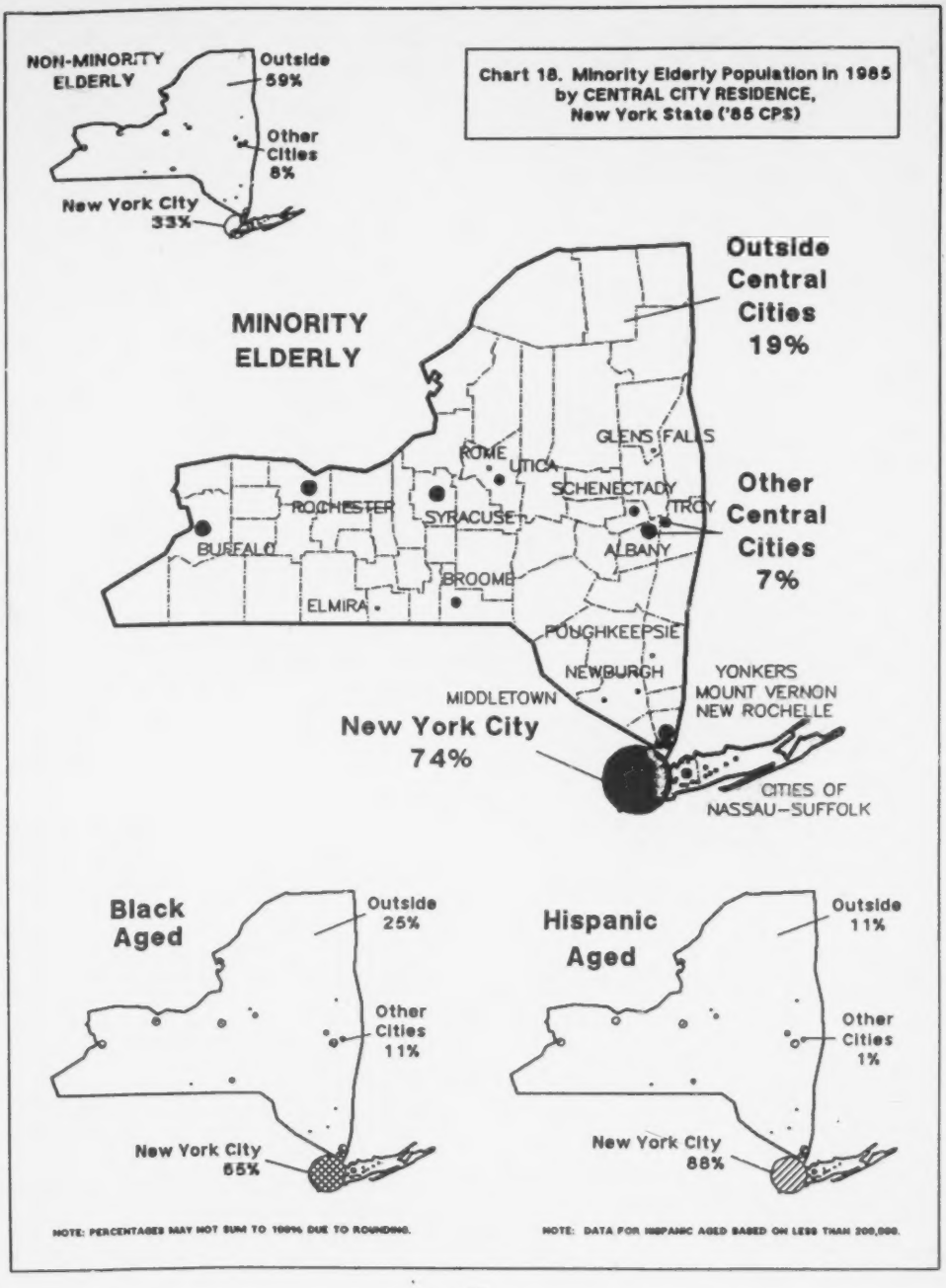
MOBILITY

The mobility of the minority elderly study population was described, in part, in an earlier section on the migration of the minority elderly into New York State from other states and abroad. Mobility within the State, moving from one residence to another, is an equally important characteristic as it affects or may result from available housing options.

Overall 14 percent of the minority elderly, in comparison to 10 percent of the non-minority elderly, were living in a different apartment or house in 1985 than they had occupied in the State in 1980. These "movers," together with those who had migrated into the State, accounted for 17 percent of the minority elderly population in comparison to only 12 percent of the non-minority elderly in the State.

Among the minority elderly:

- More than nine-in-ten (or 92 percent) of the Black elderly were living in the same home they had occupied five years earlier--while 8 percent had changed residences within the State (less than half a percent had migrated into New York State).
- Only seven-in-ten (or 69 percent) of the Hispanic elderly, however, were living in the same apartment or house they had occupied five years earlier--while 25 percent had moved from a previous residence in New York State to the one they now occupied (an additional 6 percent had migrated from another state or abroad).



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

NOTE: DATA FOR HISPANIC AGED BASED ON LESS THAN 200,000.

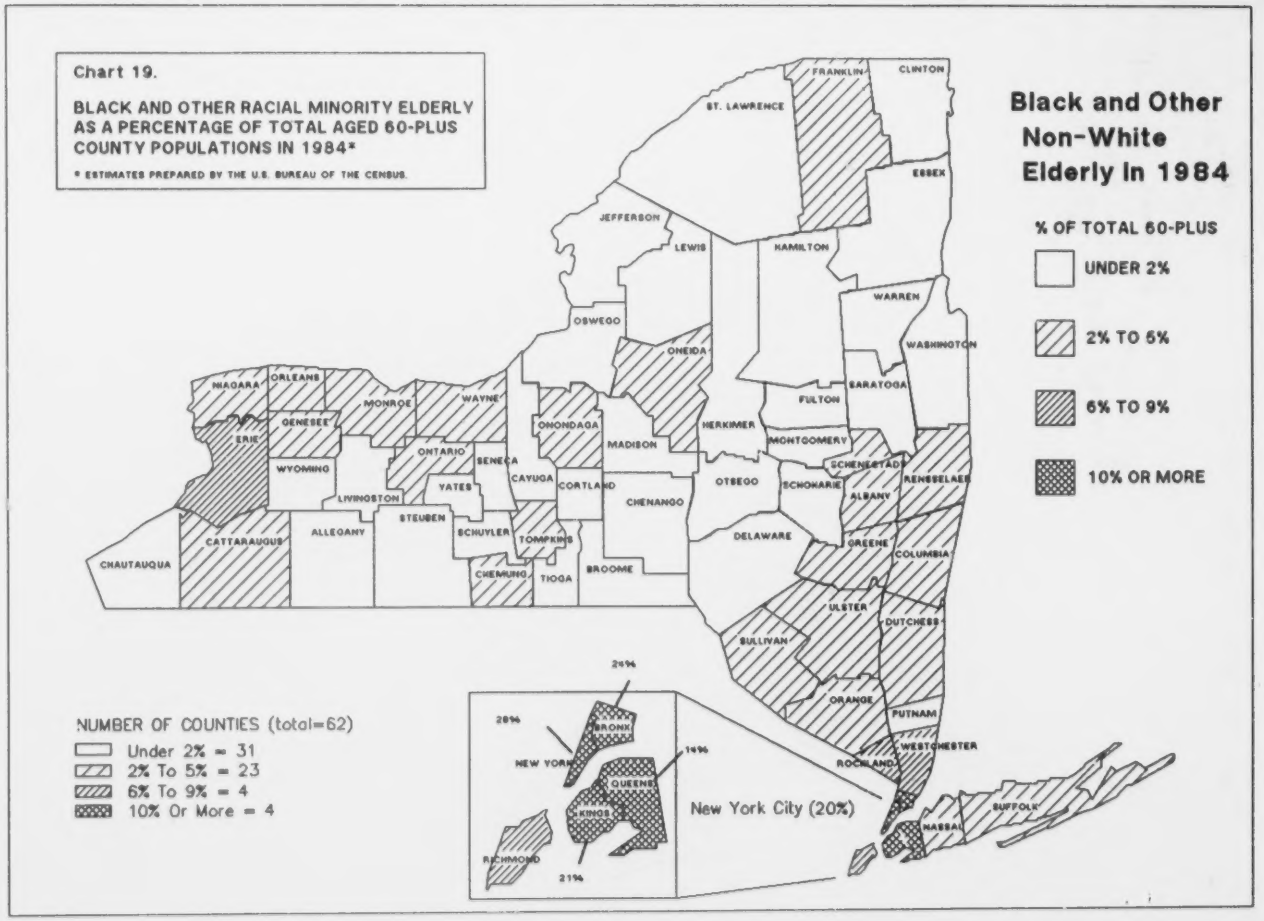
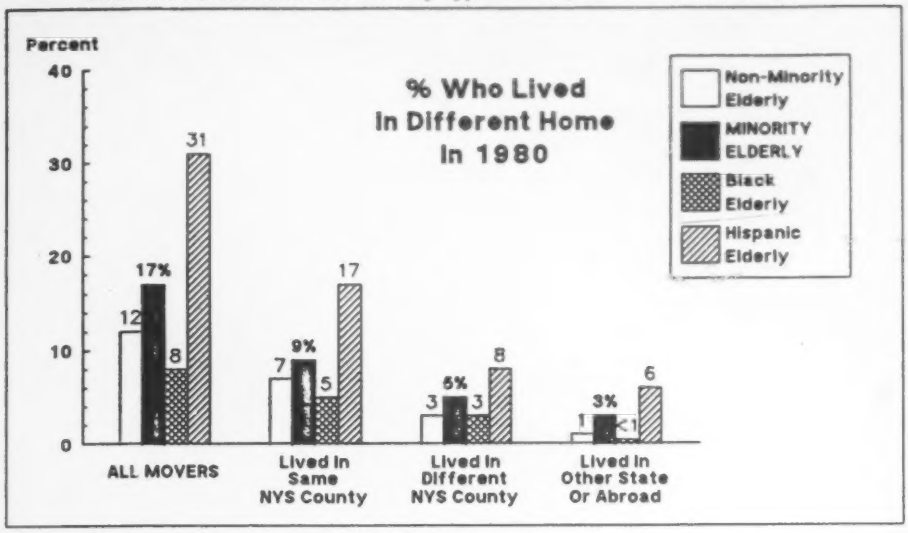


Chart 19.
BLACK AND OTHER RACIAL MINORITY ELDERLY AS A PERCENTAGE OF TOTAL AGED 60-PLUS COUNTY POPULATIONS IN 1984*
* ESTIMATES PREPARED BY THE U.S. BUREAU OF THE CENSUS.
Black and Other Non-White Elderly In 1984
% OF TOTAL 60-PLUS
UNDER 2%
2% TO 5%
6% TO 9%
10% OR MORE
NUMBER OF COUNTIES (total=62)
Under 2% = 31
2% To 5% = 23
6% To 9% = 4
10% Or More = 4
New York City (20%)
24%
28%
14%
21%
BRONX
NEW YORK
QUEENS
KINGS
RICHMOND
FRANKLIN
CLINTON
ST. LAWRENCE
ESSEX
JEFFERSON
LEWIS
HAMILTON
WARREN
OSWEGO
ONEIDA
WASHINGTON
NIAGARA
ORLEANS
MONROE
WAYNE
SARATOGA
FULTON
GENESEE
ONONDAGA
HERKIMER
MONTGOMERY
ERIE
MADISON
SCHENECTADY
WYOMING
ONTARIO
SENECA
OTSEGO
SCHOHARIE
ALBANY
RENSSELAER
CAYUGA
CORTLAND
YATES
LIVINGSTON
CHENANGO
STEUBEN
ALLEGANY
SCHUYLER
TOMPKINS
DELAWARE
GREENE
COLUMBIA
CATTARAUGUS
CHAUTAUQUA
CHEMUNG
TIOGA
BROOME
ULSTER
DUTCHESS
SULLIVAN
ORANGE
PUTNAM
WESTCHESTER
ROCKLAND
NASSAU
SUFFOLK

Chart 20. PERCENTAGE of the Minority Elderly Population in 1985 That LIVED IN A DIFFERENT HOME IN 1980 by Type of Move, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO TOTALS FOR ALL MOVERS DUE TO ROUNDING.

TENURE AND TYPE OF HOUSING

The tenure and type of housing occupied by the minority elderly is associated with the high concentration of their residences in the State's central cities. In central cities, the tenure of housing is frequently renter rather than owner occupied, and the type of housing often includes large multi-unit buildings, public housing and, for some, the dilapidated housing of inner city areas. Whether housing options dictate the minority elderly's place of residence or vice versa, tenure and type of housing are one of the major and basic differences between the living conditions of the minority elderly and the rest of the elderly population.

Tenure (Own/Rent)

The minority elderly live predominantly in rented housing and are almost twice as likely to do so than the rest of the elderly population. Conversely, the non-minority elderly are twice as likely to be living in housing they or a member of their household own.

In 1985 just under two-thirds (or 62 percent) of the minority elderly in the State lived in rented housing. They included 58 percent of the Black aged and a higher 76 percent of the Hispanic aged. Among the non-minority elderly, only one in three (or 34 percent) lived in rented housing while most (or 66 percent) lived in owned housing.

In terms of all elderly persons living in owned and rented housing:

- Ninety (90) percent of the elderly living in owned housing were non-minority elderly persons--while only 10 percent were minority aged.
- In comparison, the minority elderly comprised 26 percent--more than one-in-four--of the elderly living in apartments and other rented housing units.

Size of Building

In 1985 most of the minority elderly population lived in buildings with multiple housing units. As indicated by other housing characteristics, these buildings were typically apartment buildings located in the State's central cities.

- Only 24 percent of the minority elderly, in contrast to 55 percent of the non-minority elderly lived in single unit, stand-alone houses.
- Thirty-three (33) percent of the minority elderly, including 35 and 32 percent of the Black and Hispanic aged respectively, lived in buildings with two to nine units--in comparison to 21 percent of the non-minority elderly.
- Forty-three (43) percent of the minority elderly, including 39 and 53 percent of the Black and Hispanic aged respectively, lived in larger buildings with at least ten units--in comparison to only 24 percent of the non-minority elderly.

Public and Rent Subsidized Housing

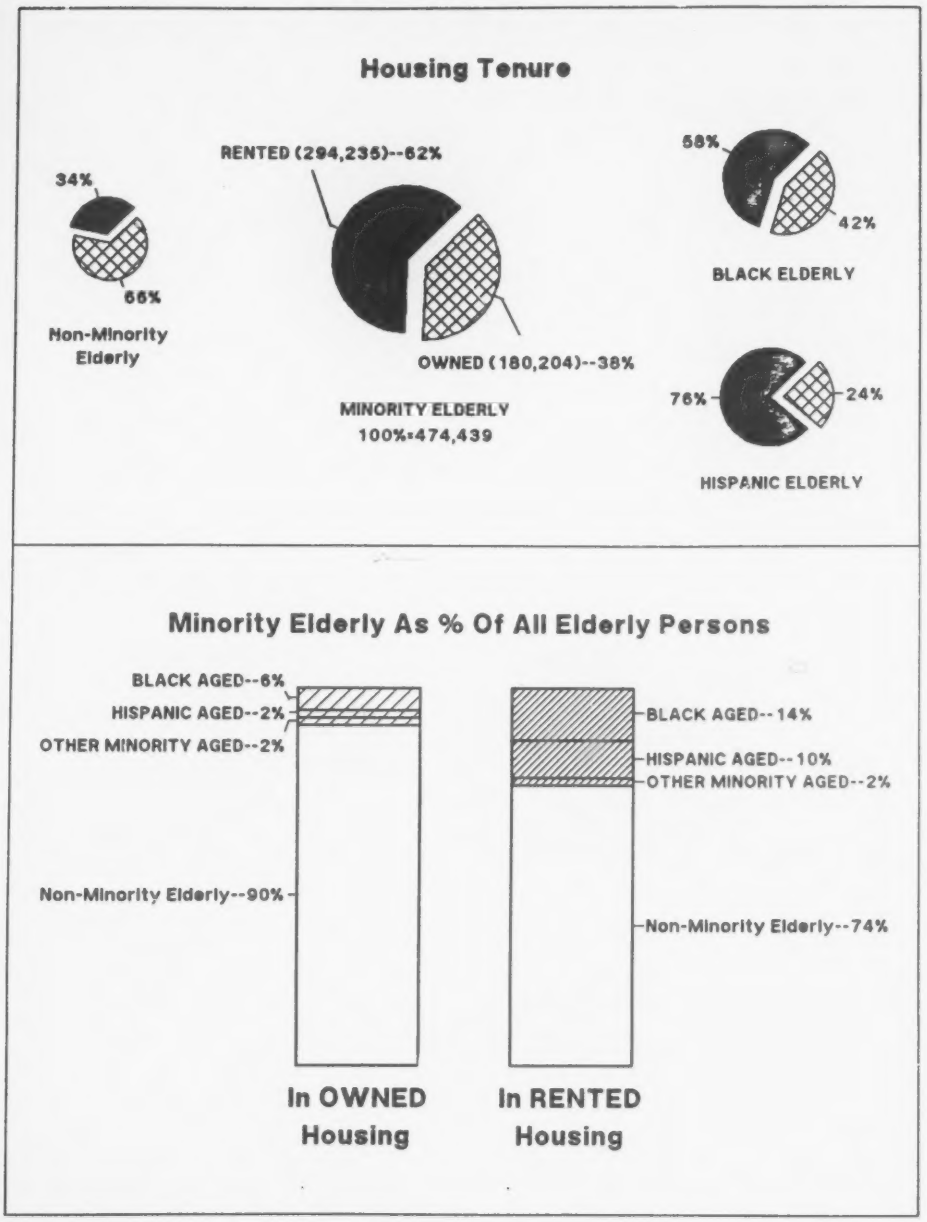
Rental housing units are comprised of public housing units, rent subsidized housing units, and private non-subsidized units which include some units occupied by persons who pay "no cash rent." (Also see Appendix E.)

In 1985 the minority aged were more likely than other elderly renters to be living in public housing, and were less likely to be living in other types of rental units. Still most of the minority elderly paid cash rent to live in private non-subsidized units as did other elderly renters.

Of all elderly persons living in renter occupied housing:

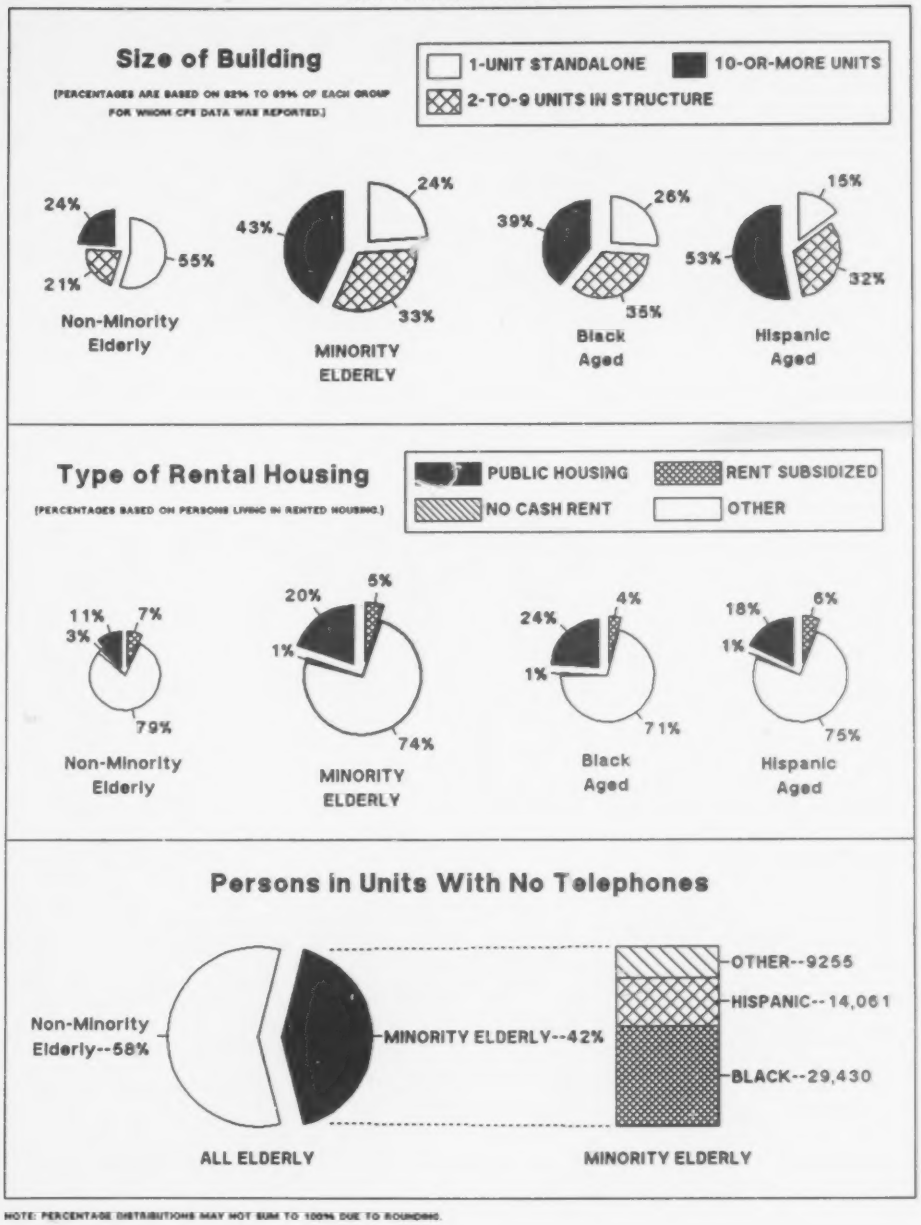
- One-fifth (or 20 percent) of the minority elderly lived in public housing, in comparison to 11 percent of the non-minority elderly.
- Most (or 74 percent) the minority elderly who rented were living and paying cash rent in private non-subsidized units--in comparison to 80 percent of the non-minority elderly.
- Only 6 percent of the minority elderly renters were living in rent-subsidized or private "no cash rent" units--in comparison to 10 percent of the non-minority elderly.

Chart 21. Minority Elderly Population in 1985 by HOUSING TENURE (OWN/RENT), New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

Chart 22. Minority Elderly Population in 1985 by TYPE OF HOUSING, New York State ('85 CPS)



NOTE: PERCENTAGE DISTRIBUTIONS MAY NOT SUM TO 100% DUE TO ROUNDING.

In all, 38 percent of the elderly living in public housing were minority elderly persons -- in comparison to:

- Twenty-five (25) percent of the elderly living and paying cash rent in private rental units; and,
- Twenty-three (23) percent of the elderly living in rent subsidized units.

Telephone Availability

The quality of the housing units occupied by the minority elderly is too often typified by delapidation, over-crowding, and the lack of basic facilities[18] which are usually taken for granted in today's society. Inadequate housing characterizes poverty stricken inner city areas and more broadly reflects the generally lower economic status of the minority elderly.

One characteristic indicative of inadequate housing is the simple lack of a telephone. For the elderly who are frequently isolated (even in the largest cities) and at risk of needing emergency assistance, the unavailability of a telephone in the home can be a matter of life and death.

Few homes would be without a telephone today, yet in 1985:

- More than 1-in-10 minority aged in the State had no telephone in their home--11 percent or over 52,000 minority elderly persons (including 11 and 9 percent of the Black and Hispanic aged respectively).
- The minority elderly were almost three times as likely to be without a telephone than the rest of the elderly population--11 percent compared to only 3 percent of the non-minority elderly population had no telephone.
- The minority elderly accounted for 42 percent of all elderly persons who had no telephone in their home--in comparison to their much smaller 16 percent of the elderly population as a whole.

6. Employment Characteristics

An estimated 119,000 of the minority elderly population in 1985 had been employed, earning wages, salaries or self-employment income during the prior year. An additional 77,000 minority elderly persons would have been employed if not for illness or disability. Together, these persons represented two out of every five (or 41 percent) of the minority aged--in comparison to the 33 percent accounted for by their counterparts among the non-minority elderly.

For the elderly, employment statistics represent a complex indicator of how older persons, and society, resolve often conflicting influences. Declining health may compete with economic need, job satisfaction may compete with early retirement benefits, and the intrinsic rewards of being active outside the home may compete with the need to remain home to care for an ailing spouse. When comparing different populations, further factors may be introduced including differences in age structures and, most important, the bias of unequal opportunity.

This chapter will present employment statistics for the twelve months of 1984. During this period, some of the persons who comprised the aged 60-plus elderly population in 1985 were still 59 years old. Others were still 61 years old and not yet eligible for the age 62 "early retirement" benefits under Social Security; and, others were still 64 years old and not yet eligible for full Social Security benefits. In effect, the employment statistics for 1984 will describe an "elderly" population that was one year younger and included a group who faced or were actively resolving the retirement decision.

EMPLOYMENT AND OCCUPATION IN 1984

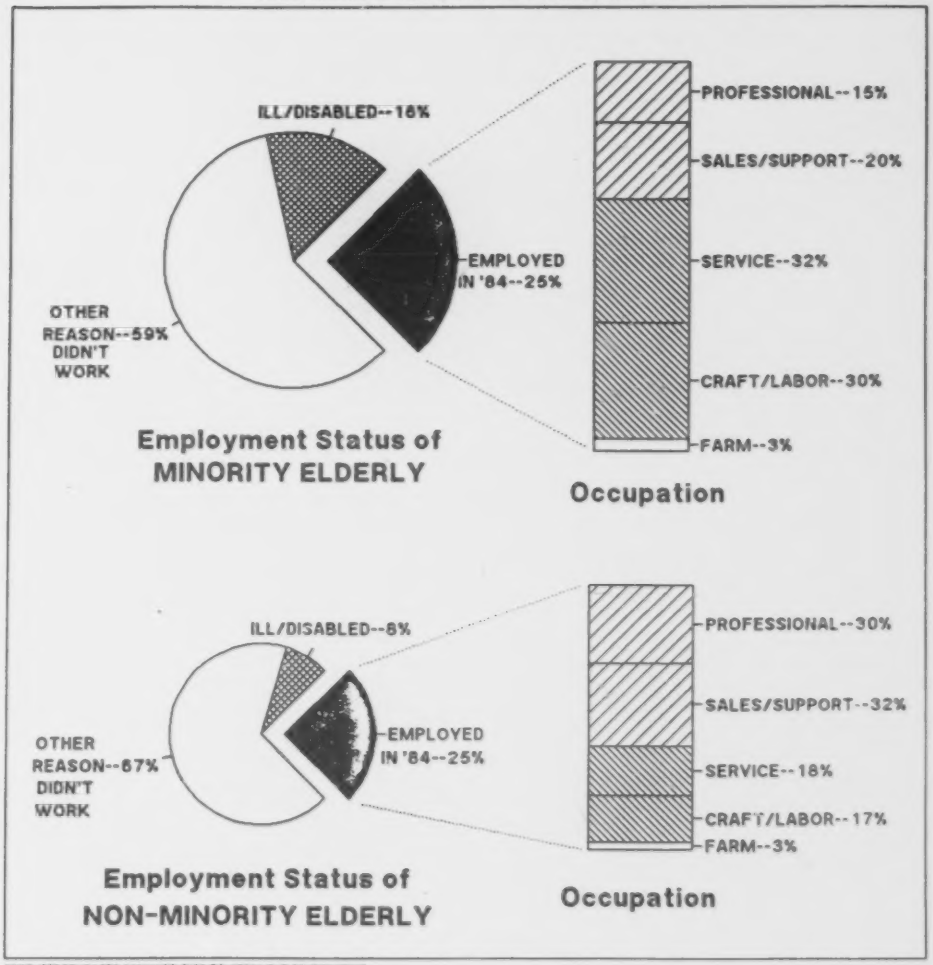
These "prior year" employment statistics[19] for the minority elderly population directly reflect the poorer health which typically afflicts the minority elderly at younger ages--and the bias and discrimination in opportunity which, rooted in the history of American society, exists today in the occupations open to the minority aged for continued employment.

Of the minority elderly in the State in 1985, one out of every four (or 25 percent) were employed and earned wages, salary or self-employment income during 1984--a proportion equaling the 25 percent of the non-minority elderly who were employed. However:

- Almost two-out-of-three or 62 percent of the estimated 119,000 minority aged employed in 1984 worked at a service or other "blue collar"/"unskilled" occupation--in comparison to only a third or 35 percent of the non-minority elderly who were employed.

- Conversely, only 35 percent of these minority elderly were employed in professional or other "white collar"/"skilled" occupations--in comparison to most or 62 percent of the non-minority elderly.

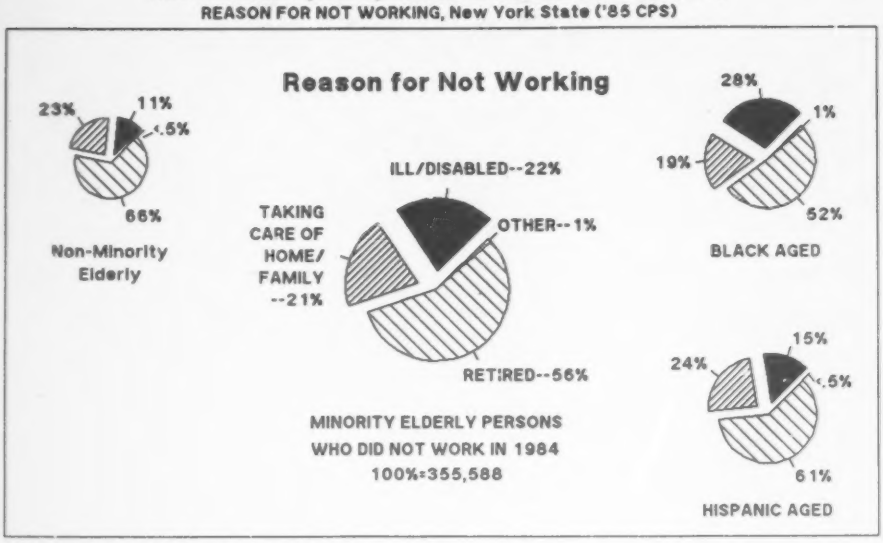
Chart 23. Minority Elderly Population in 1985 by EMPLOYMENT STATUS and OCCUPATION IN 1984, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

Such major differences in occupations reflect not only past inequities in educational and employment opportunities, but the inequities in the continued employment and retirement benefit options now available to the older minority population.

Chart 24. Minority Elderly Persons Who Did Not Work in 1984 by REASON FOR NOT WORKING, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

REASON DID NOT WORK

Most minority elderly New Yorkers, as they reach retirement age, are already disadvantaged by the limited continued employment opportunities and retirement benefits associated with their occupation. This disadvantage is further aggravated by the early onset of illnesses and disabilities typically experienced by the minority elderly. Rather than facing a voluntary retirement decision based on their economic situation, many minority elderly may well have their opportunity to earn taken away by deteriorating health.

Of the total minority elderly population in 1985, one-in-six (or 16 percent) did not work the prior year because of illness or disability. This compares to less than one-in-twelve (or only 8 percent) of the non-minority elderly.

In all, more than two out of every five minority elderly persons--an estimated 196,000 or 41 percent--were employed during 1984 or would have been if not for illness or disability. This includes just under half (or 45 percent) of the Black aged and more than a third (or 35 percent) of the Hispanic aged.

Still, of the minority elderly who were not employed during the prior year:

- Most or 56 percent (including 52 and 61 percent of the Black and Hispanic aged respectively) did not work because they were retired--in comparison to 66 percent of the rest of the elderly population.

- A fifth or 22 percent of this group (including 28 and 15 percent of the Black and Hispanic aged respectively) were those who did not work because of illness or disability--in comparison to only 11 percent of the non-minority elderly.

- Another fifth or 21 percent (including 19 and higher 24 percent of the Black and Hispanic aged respectively) did not work because they were taking care of their home and family--in comparison to 23 percent of the non-minority elderly.

7. Personal Income

The amount of personal income received by the minority aged documents the serious economic disadvantage they typically face. Though the elderly are generally a low income population, minority elderly persons have been placed in double jeopardy--by the educational and employment opportunities denied them, and by the burden of age on their health and income.

Personal income is the amount of money the individual receives from all regular income sources including employment, pension and Social Security benefits, interest and other regular income from savings and investments, and essentially all other sources. By definition, personal income is limited to moneys received and does not include the monetary value, if any, of in-kind goods or services received from either private or government sources.

This chapter describes the income of the minority elderly in terms of the distribution of individuals by the amount of their personal income, and the total sum or 'aggregate' amount of the income of all persons in the population. Income as described in this, as well as in subsequent chapters, is the personal income of the 1985 study population during the prior year, i.e., annual income in 1984.

Chart 25. Minority Elderly Population in 1985 by MEDIAN INCOME IN 1984, New York State ('85 CPS)

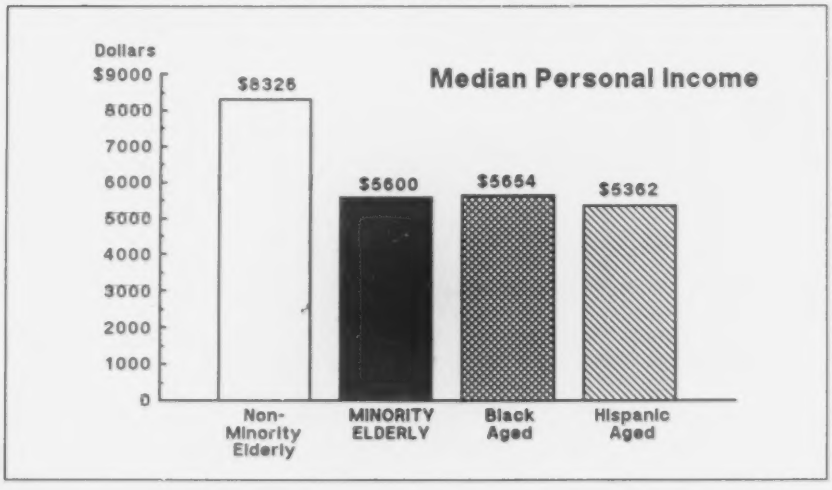
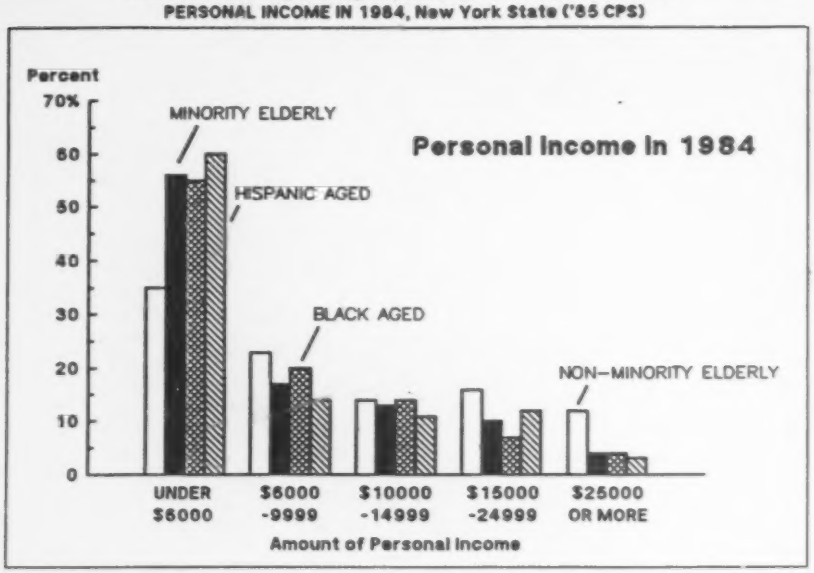


Chart 28. Minority Elderly Population in 1985 by AMOUNT OF PERSONAL INCOME IN 1984, New York State ('85 CPS)



PERSONAL INCOME DISTRIBUTION

One out of every two minority elderly persons in New York State in 1985 had personal incomes of under $5,600 during the prior year--less than $467 A MONTH. More than one-in-four (or 27 percent) received under $4,000--less than $335 a month or an average of less than $11 a day over the course of the year.

In comparison to the already low median income of the non-minority elderly--$8,326 during 1984:

- The minority elderly population had a median income of only $5,600--only two-thirds that of the non-minority elderly.
- The Black aged had a median income of $5,654.
- The Hispanic aged had a median income of $5,362.

With half having personal incomes below these medians, three-out-of-four (or 73 percent) of the minority aged in all had personal incomes amounting to less than $10,000--including 75 and 74 percent, respectively, of the Black and Hispanic aged. Most, but a smaller 58 percent of the rest of the elderly population had incomes this low.

An additional 13 percent of the minority elderly (including 14 and 11 percent of the Black and Hispanic aged respectively), and similiar 14 percent of the non-minority elderly had personal incomes of $10,000 to under $15,000.

The economic disadvantage of the minority elderly, and indeed the low economic status of the elderly as a whole, means not only a concentration of individuals at low income levels, but also a sparsity of older persons at the income levels normally reached by much of the younger population.

Only an estimated 754,000 older New Yorkers OUT OF A TOTAL POPULATION OF 3 MILLION had personal income of as much as $15,000 in 1984. They included:

- Only 14 percent of the minority elderly (11 and 15 percent of the Black and Hispanic aged respectively)--in comparison to 28 percent of the non-minority elderly.
- Only 9 percent of the minority elderly whose incomes were as much as $20,000 or more--9 and 7 percent of the Black and Hispanic aged respectively.
- Only 4 percent of the minority elderly with personal incomes of $25,000 or more--4 and 3 percent of the Black and Hispanic aged respectively.

The severe economic disadvantages the minority aged face are apparent when comparing these figures to those for the rest of the elderly population. The non-minority elderly were:

- Twice as likely to have incomes of $15,000 or more--28 percent had such incomes.
- Twice as likely to have incomes of $20,000 or more--18 percent had such incomes.
- Three times as likely to have $25,000 or more in personal income in 1984--12 percent in comparison to only 4 percent of the minority elderly.

Chart 27. 1984 PER CAPITA INCOME of the Minority Elderly Population, New York State ('85 CPS)

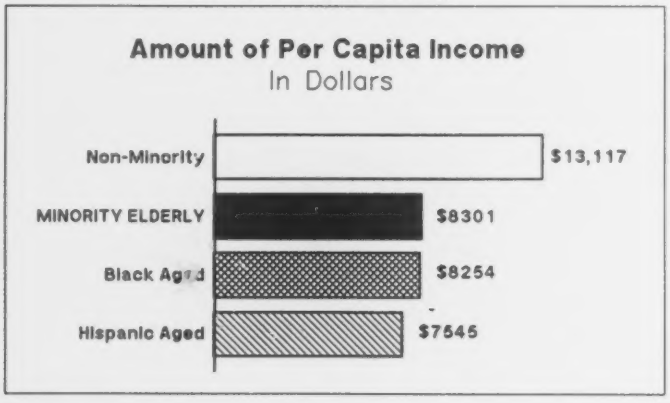


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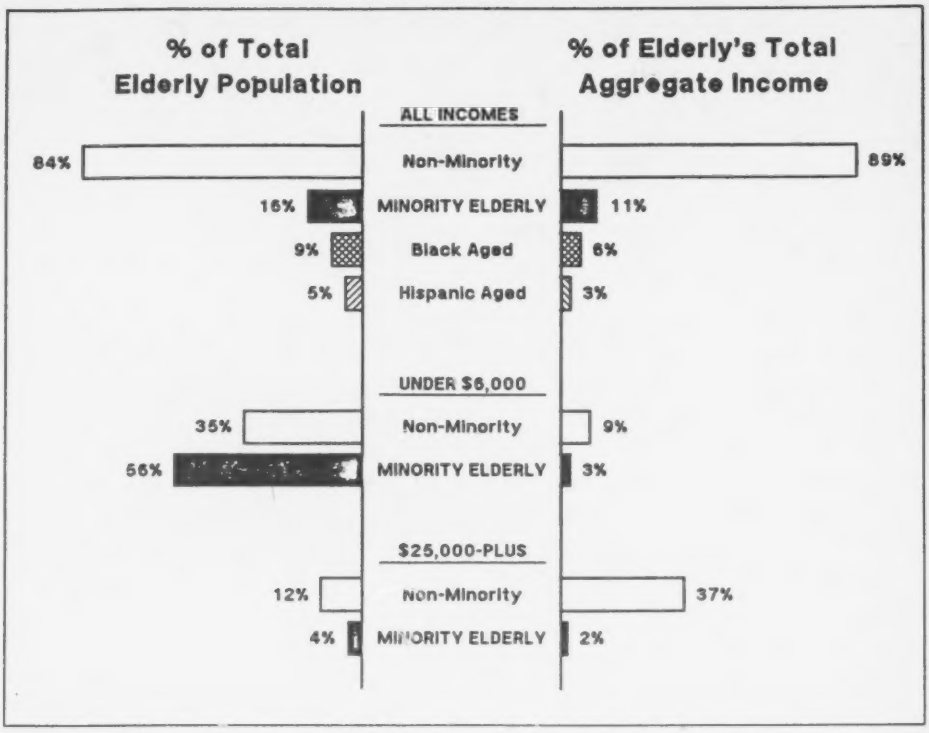
Chart 28. 1984 AGGREGATE INCOME of the Minority Elderly Population in 1985 AS A PERCENT of the Aggregate Income of the TOTAL ELDERLY POPULATION, New York State ('85 CPS)



AGGREGATE AND PER CAPITA INCOME

The aggregate and per capita income of the minority elderly population in 1984 (i.e., the arithmetic sum and mean of the personal income of all individuals) further reflects the relative disadvantage of the minority aged, and also the disproportional share of income accounted for by the small number of elderly persons with annual incomes of $25,000 or more.

The minority elderly's aggregate income in 1984 amounted to $8,301 per capita ($8,254 and $7,545 respectively for the Black and Hispanic aged)--in comparison to $13,117 per capita for the non-minority elderly population.

The minority aged represented 16 percent of the State's total elderly population, but received only 11 percent of the population's total aggregate income. Of the minority elderly:

- o The Black aged, representing 9 percent of the elderly population in 1985, received only 6 percent of the population's total aggregate income during the prior year; and,

- o The Hispanic aged received only 3 percent while comprising 5 percent of the total elderly population.

Further, of the aggregate income received by the minority aged, 17 percent was accounted for by only that 4 percent of the minority elderly with incomes of $25,000 or more.

In comparison, the aggregrate income of the non-minority elderly was even more concentrated among those with higher incomes. Forty-one (41) percent of the non-minority elderly's aggregate income was accounted for by 12 percent whose had income of $25,000 or more.

Overall, of the aggregate income of the total elderly population:

- o Well over a third or 37 percent was received by that 10 percent of all older New Yorkers who were non-minority elderly with incomes of $25,000 or more.

- o Two (2) percent was received by the fewer than 20,000 minority aged at the $25,000 and over income level--with indeed only 11 percent received by the entire minority elderly population.

- o Only 11 percent was received by that 29 percent of all older New Yorkers who were non-minority elderly with incomes under $6,000.

- o Only 3 percent was received by that 9 percent of all older New Yorkers who were minority aged with incomes under $6,000.

8. Sources of Income

The minority elderly population derives most of its income from sources directly affected by inequities in employment and past educational opportunities. Earnings from employment in 1984 were the single largest source of income for the population. And the amount of earnings reflects the lower wages and salaries typically associated with the occupations of the minority aged.

Similarly Social Security benefits were an almost equally large share of the minority elderly's aggregate income, but again reflect their economic disadvantage, in part, simply because benefit amounts are directly calculated from the earnings history of the retiring worker.

Denial of equal opportunity has further shaped the income of the minority elderly by not only limiting, but by denying them additional souces of income. Restrictions in pension benefits associated with blue collar occupations, and limitations on prior earnings that restrict retirement income from savings and investments have both contributed significantly to lowering the current income of the minority elderly, and to forcing them into the Supplemental Security Income or public assistance programs which typically provide less than a poverty level income.

In general, five sources of income account for 98-to-99 percent of the minority as well as non-minority elderly population's aggregate income. This chapter describes the aggregate and per capita income derived from each, and the number of minority elderly who actually received any income from each source in 1984. The five sources or types of income are:

-- earnings which include wages, salaries and net income from self-employment;

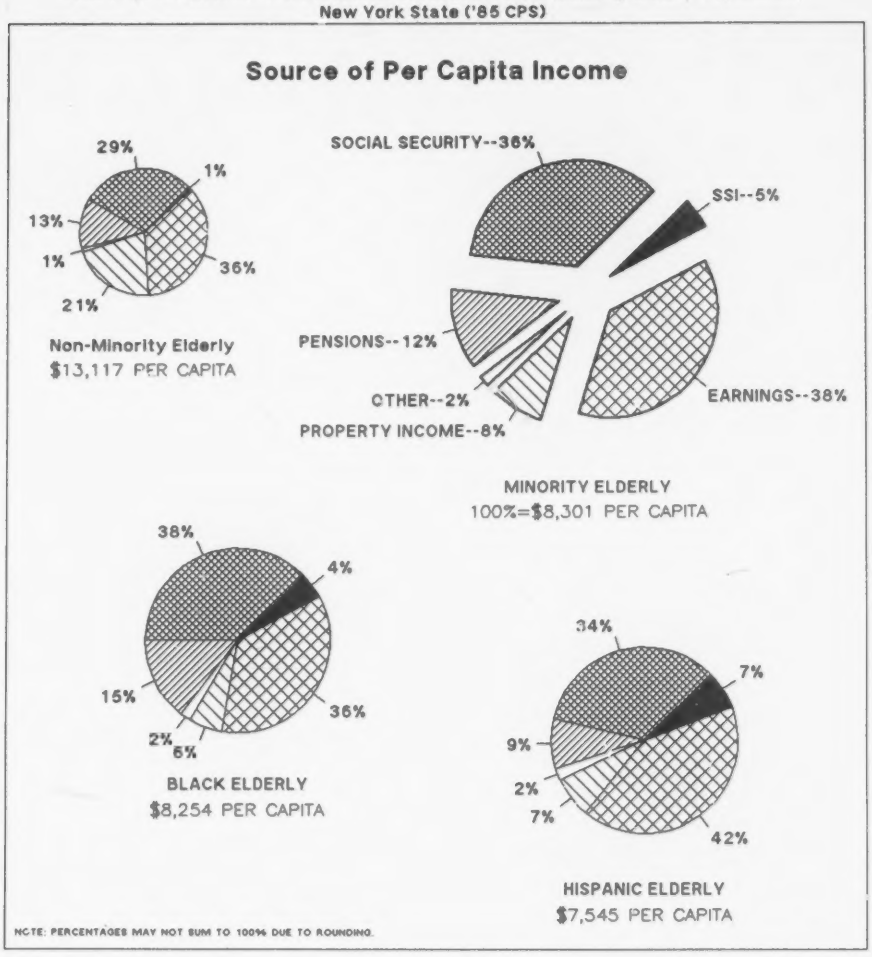
-- Social Security benefits (inclusive of Railroad Retirement);

-- pensions which include income from private annuity and retirement accounts (inclusive of Individual Retirement Accounts or "IRAs"), and from private and public pension funds or retirement systems;

-- "property" income which means interest from savings, dividends from stocks, and other regular income derived from "personal property" as well as net rental income from rented apartments or other "real property"; and,

-- Supplemental Security Income (SSI) which are payments received under the SSI Program for the low income aged (persons 65 and older), blind and disabled to supplement other income up to minimum income levels set by law.

Chart 29. SOURCE OF 1984 PER CAPITA INCOME of the Minority Elderly Population, New York State ('85 CPS)



AGGREGATE AND PER CAPITA AMOUNTS

Earnings and Social Security were by far the two primary sources of the minority elderly's income in 1984--accounting for a total of $74 out of every $100 of their per capita income. Considerably less was received from pensions, interest and other property income, and SSI payments which ranked third through fifth, respectively.

Out of every $100 of per capita income, the minority elderly received:

- o $38 from earnings--$36 and $42 for the Black and Hispanic aged respectively;
- o $36 from Social Security--$38 and $34 for the Black and Hispanic aged respectively;
- o $12 from pensions--$15 and $9 for the Black and Hispanic aged respectively;
- o $8 from interest ($6) and other property income ($2)--$6 and $7 for the Black and Hispanic aged respectively;
- o $5 from Supplemental Security Income payments--$4 and $7 for the Black and Hispanic aged respectively; and,
- o $2 from other sources such as Veteran Benefits and Worker's Compensation--$2 and $2 for the Black and Hispanic aged respectively.

The non-minority elderly, in comparison, also relied on earnings and Social Security benefits as the first and second largest sources of their aggregate income in 1984--but these two sources accounted for a smaller $65 out of every $100 of their per capita income. Interest and other property income, rather than pensions, was their third ranking source and contributed significantly to their overall per capita. Pensions were their fourth ranking source, followed by SSI payments which ranked a distant fifth.

In absolute dollars per capita, the minority elderly received:

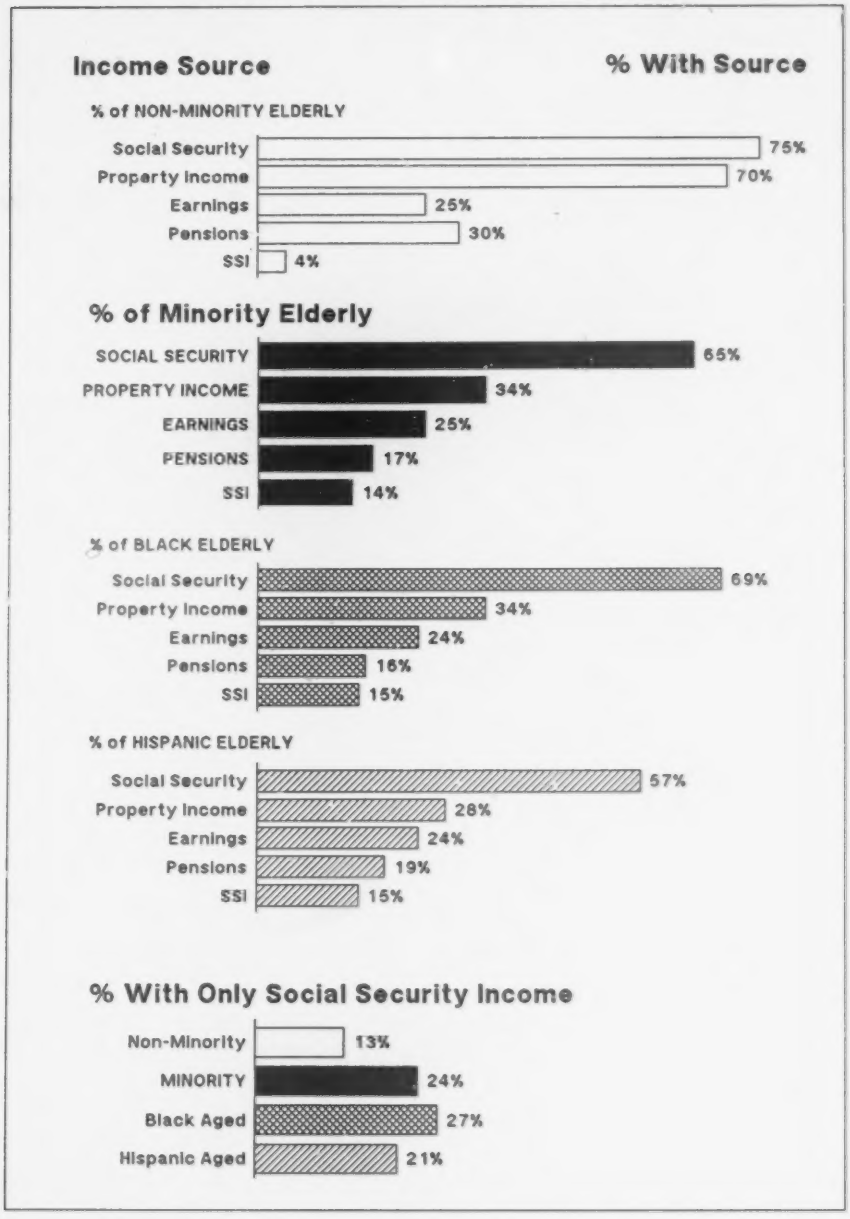
- o $3,115 in earnings--in comparison to a 150% larger $4,660 per capita for the non-minority elderly;
- o $2,964 in Social Security benefits--in comparison to a 128% larger $3,783 per capita for the non-minority elderly;
- o $1,026 in pension income--in comparison to a 162% larger $1,666 per capita for the non-minority elderly;
- o $676 in interest and other property income--in comparison to an over 400% larger $2,778 per capita for the non-minority elderly; and,
- o $383 in SSI payments for the low income aged, blind and disabled--in comparison to only $77 per capita for the non-minority elderly.

RECIPIENTS AND AMOUNT RECEIVED

The relative importance of different sources of income for the minority elderly is further described by the number of persons who actually received income from each source, and by the average amount of income these persons ("recipients") received.

Social Security was the ONLY type of income received by more than a third of the minority aged in the State. Most minority elderly received Social

Chart 30. Percent of Minority Elderly Persons RECEIVING INCOME FROM SELECTED INCOME SOURCES IN 1984, New York State ('85 CPS)



Security benefits in 1984, but simply did not have those other sources of income which the rest of the elderly population find so important to their economic well-being.

In 1984:

- Two-thirds or 65 percent of the minority elderly (including 69 and 57 percent of the Black and Hispanic aged respectively) had income from Social Security benefits--in comparison to a larger 75 percent of the non-minority elderly.

- Only one-third or 34 percent of the minority elderly (including 34 and 28 percent of the Black and Hispanic aged respectively) had income from interest on savings or other property sources--in comparison to most or 70 percent of the non-minority elderly.

- One-in-four or 25 percent of the minority elderly (including 24 percent of both the Black and Hispanic aged) had earnings from employment during 1984--as did 25 percent of the non-minority elderly.

- Only 17 percent of the minority elderly (including 16 and 19 percent of the Black and Hispanic aged respectively) had income from private or public pensions or retirement funds--in comparison to just under a third (or 30 percent) of the non-minority elderly.

- Fourteen (14) percent of the minority elderly (including 15 percent of both the Black and Hispanic aged) had income from Supplemental Security Income payments--in comparison to only 4 percent of the non-minority elderly.

As a result of the disproportionally low recipiency of income from sources such as pensions and property income, the minority elderly, and particularly the low income minority elderly, are especially dependent on governmental policies which often affect their sole source of income. The 65 percent of the minority elderly who had Social Security income in 1984 included:

- 24 percent of the minority elderly who had NO other source of income;

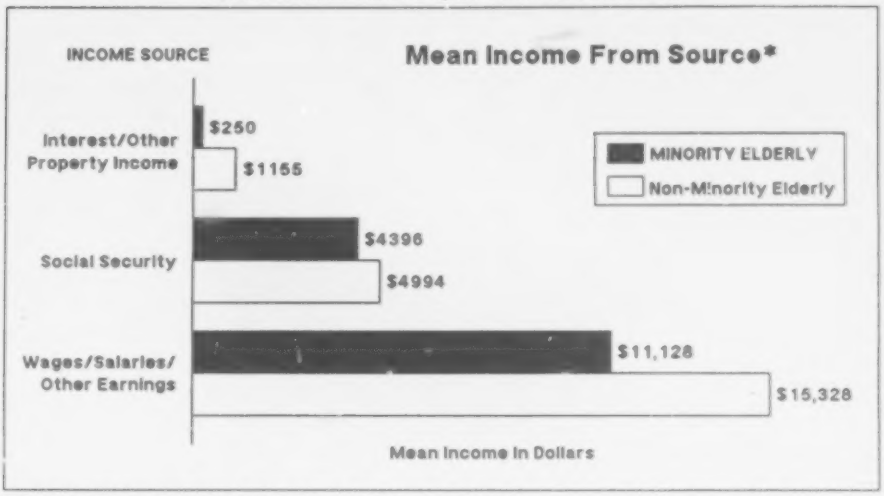
- 27 percent of the Black aged who relied solely on Social Security benefits for their income; and,

- 21 percent of the Hispanic aged who had no other income.

Minority elderly persons dependent solely on Social Security together with those who received SSI payments, represented 38 percent--or over 178,000--of the State's minority elderly population. Their total income is directly controlled by governmental policies--policies which are annually debated under the political pressures of interest groups and conflicting constituencies. They include 42 percent of the Black aged, and 36 percent of the Hispanic aged in New York State.

To the extent that average income figures are available[20] these averages clearly document the economic disadvantage, even of the minority elderly who

Chart 31. MEAN INCOME FROM SELECTED SOURCES* for Minority Elderly Persons WITH SUCH INCOME IN 1984, New York State ('85 CPS)



* MEANS ARE NOT SHOWN FOR AN INCOME SOURCE IF LESS THAN 50,000 MINORITY ELDERLY PERSONS RECEIVED INCOME FROM THAT SOURCE.

had income from specific sources. In 1985 the median income of those who had such income was:

- o $4,396 in Social Security income for older minority beneficiaries--in comparison to $4,994 for the non-minority elderly;
- o $11,128 in earnings for the 25 percent of the minority aged who were employed--in comparison to $15,328 for the non-minority elderly; and,
- o Less than $250 in property income for minority elderly with interest or other property sources--in comparison to $1,155 for the non-minority elderly.

9. Poverty and Income Status

The minority elderly are a heterogeneous population and many live above the poverty level at lower, middle and higher income status levels. Not all minority elderly are poverty stricken, yet the inequitable concentration of poverty among the minority elderly is undeniable. Poverty is too often the end result of the inequities the minority elderly have faced from discrimination and the loss of educational and employment opportunities, and the earlier losses of good health and spouses when growing old.

The minority elderly's income is often limited both in the number of sources and amount they receive. The double jeopardy of being a minority and being old means that poverty may result from either or both. For some minority elderly, poverty may have been a fact of life prior to old age, and the costs of growing older became a further burden on an already inadequate income. For many others, however, poverty has come with the costs of medical care, lost employment and the erosion of resources and income associated with growing old.

"Poverty" was first defined by the federal government in the mid-1960s as the costs of food and other necessities needed by the "family-unit" to maintain a subsistence standard of living. Income thresholds were established for family-units of different size and composition. Since then, these thresholds have been adjusted annually for changes in the costs-of-living based on the annual average Consumer Price Index. If persons live in family-units whose total income is less than offical threshold amounts, they are recognized as living "in poverty" (or "below the poverty level").

The official poverty thresholds for 1984 were (also see Appendix C) as follows:

- o $4,979 for a one-person family-unit aged 65 or older (i.e., for a person aged 65-plus who lived alone), and $5,400 if the older person was 60 to 64 years old; and,

- o $6,275 for a couple aged 65 or older (i.e., two persons living alone where the householder is 65-plus), and $6,951 if 60 to 64 years old.

As described in an earlier chapter, the minority elderly often live in larger family-units of four or more persons. Frequently such extended family living arrangements are a result of economic pressures as the older person or others in the family-unit have inadequate income to maintain separate homes. The poverty which causes such arrangements is often hidden by the thresholds for larger family units and the summing of income used to officially measure poverty.[21]

In 1984 the thresholds for larger family-units with one child under 18 years old, ranged from $8,355 for three persons up to $23,102 for nine persons or more. For more prevalent family-unit sizes, the thresholds were $10,882 for four persons, $12,912 for five persons, and $13,100 for six-person

family-units. Many of the minority elderly living in these larger family-units may well have incomes below the thresholds for older persons and couples who live alone in their own homes. These minority elderly and other elderly persons will often be found at what has been called the "marginal poverty" level.

"Marginal poverty" as used here is defined as 150% of the official poverty thresholds. Those persons with family-unit incomes above the poverty threshold but less than 150% of the thresholds are considered to be "in marginal poverty." They include many of the hidden poor as well as many of the elderly whose current medical or other higher-than-average living expenses have effectively thrown them into poverty. (See Appendix C for marginal poverty thresholds in 1984.)

IN POVERTY

An estimated 121,000 of the minority elderly in New York State were living in poverty during 1984--26 percent of all minority older New Yorkers. They included one out of every four Black aged, and one out of every three Hispanic aged--poverty rates of 25 and 32 percent respectively. The minority elderly were more than three times as likely to be living in poverty than the non-minority elderly.

Out of over 331,000 elderly New Yorker who were below the poverty level in 1984:

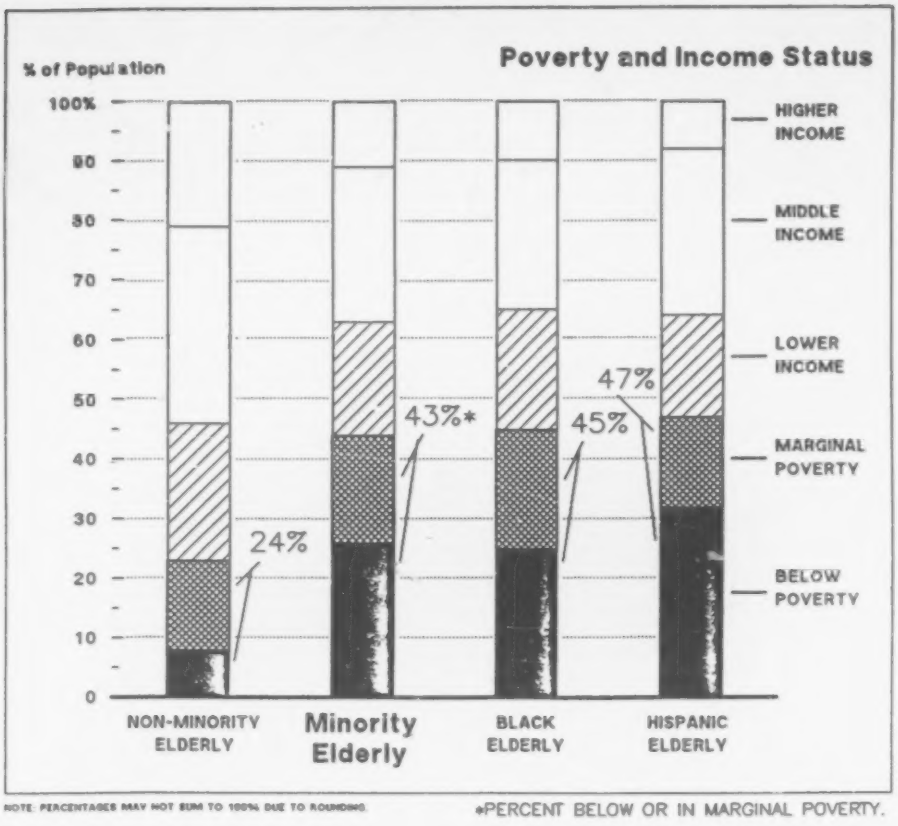
- o One-in-five or 21 percent were Black aged--in comparison to 9 percent of the elderly population.
- o One-in-seven or 15 percent were Hispanic aged--in comparison to 5 percent of the population.
- o In total, more than one-in-three or 37 percent were minority elderly persons--in comparison to 16 percent of all elderly New Yorkers.

IN AND BELOW MARGINAL POVERTY

In addition to those below the poverty level in 1984, an estimated 84,000 minority elderly were living in marginal poverty. In total, 205,000 of the minority elderly were living in poverty or marginal poverty in 1984:

- o 18 percent of the minority elderly were in marginal poverty with a total of 43 percent below the marginal poverty level;
- o 20 percent of the Black aged were in marginal poverty with a total of 45 percent below the marginal poverty level;
- o 15 percent of the Hispanic aged were in marginal poverty with a total of 47 percent below the marginal poverty level; and in comparison,
- o 15 percent of the non-minority aged were also in marginal poverty but a smaller 24 percent in total were below the marginal poverty level.

Chart 32. Minority Elderly Population by POVERTY AND INCOME STATUS IN 1984, New York State ('85 CPS)



NOTE: PERCENTAGES MAY NOT SUM TO 100% DUE TO ROUNDING.

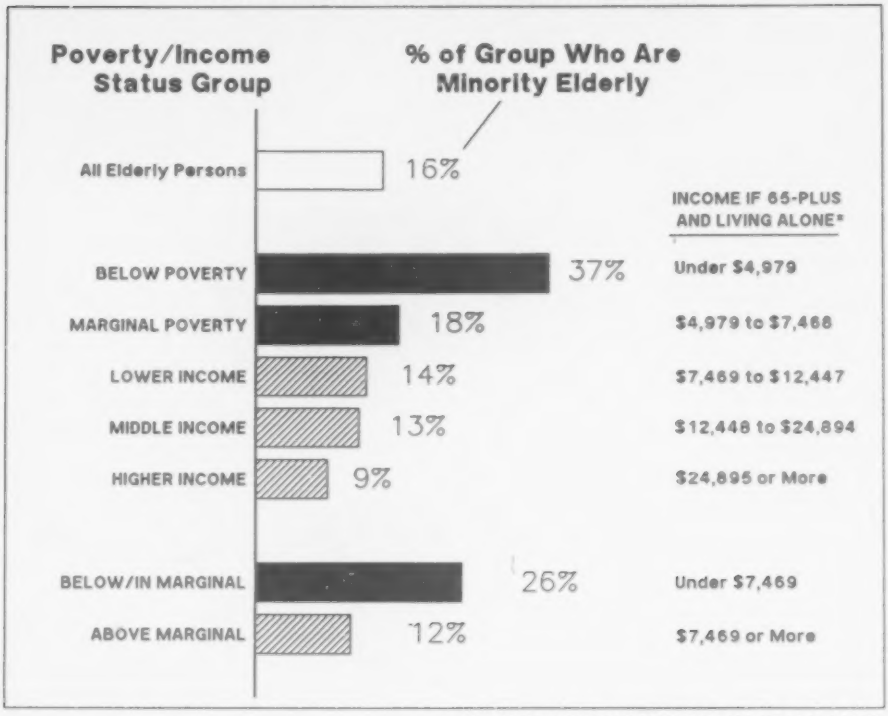
*PERCENT BELOW OR IN MARGINAL POVERTY.

Over 790,000 older New Yorkers in all were living in poverty or marginal poverty in 1984 including approximately 460,000 at the marginal poverty level. The minority and non-minority elderly are proportionally represented among those in marginal poverty. But when added to those living in poverty, the extreme disproportionate rate of poverty among the minority elderly is still apparent.

Out of the over 790,000 elderly persons below or in marginal poverty:

- o 26 percent or 205,000 in total were minority elderly;
- o 15 percent or approximately 123,000 were Black aged; and,
- o 9 percent or approximately 72,000 were Hispanic aged.

Chart 33. Minority Elderly Persons AS A PERCENT of ALL Elderly Persons by POVERTY AND INCOME STATUS, New York State ('85 CPS)



*SEE APPENDIX C FOR THRESHOLDS FOR OTHER AGES AND HOUSEHOLD SIZES

ABOVE MARGINAL POVERTY

Over-represented among those below marginal poverty, the minority elderly are under-represented among those above the marginal poverty level. These elderly persons include everyone above the 150% or marginal poverty thresholds. Their economic situation may range from a "lower-income," to a broad "middle-income," to a "higher-income" status level. While reflecting only relative differences, these three "income status" levels, defined by percentages of the offical poverty thresholds (see Appendix C), are useful in describing the major differences in the general economic situations of those above the marginal poverty level.

Overall, only 57 percent of the minority elderly, in comparison to 76 percent of the non-minority elderly, were above the marginal poverty level in 1984. They included:

- o 19 percent of the minority elderly (21 and 17 percent of the Black and Hispanic aged respectively) who were at the lower-income level--in comparison to 23 percent of the non-minority elderly;

- 26 percent of the minority elderly (23 and 28 percent of the Black and Hispanic aged respectively) who were at the much broader middle-income level--in comparison to 33 percent of the non-minority elderly; and,

- only 11 percent of the minority elderly (10 and 8 percent of the Black and Hispanic aged respectively) who were at the higher-income level--in comparison to 21 percent of the non-minority elderly.

While most of the minority elderly were above marginal poverty, those below marginal poverty together with those at the lower-income level comprised close to two-thirds or 62 percent of the entire minority elderly population.

In other words, most (or 62 percent) of the minority elderly were in fact at the poverty or lower-income levels, while most (or 54 percent) of all other elderly persons were at the middle-, or higher-income levels. Most of the Black aged (66 percent) as well as most of the Hispanic aged (64 percent) were at the lower-income level or below marginal poverty.

Still one-in-four or 26 percent of the minority elderly were at the middle-income level in 1984, including 23 and 28 percent of the Black and Hispanic aged respectively. While an additional 11 percent of the minority elderly were at the higher-income level (10 and 8 percent of the Black and Hispanic aged respectively), they were especially under-represented comprising only 9 percent of the higher-income elderly.

It is important to recognize that, even though most minority elderly persons were at lower- and poverty-income levels, 37 percent were at the middle-, or higher-income levels in 1984.

It is equally important to recognize that many of these elderly persons, as well as the much larger 54 percent of the non-minority at these income status levels, were under 65 years old and had income from employment during 1984. As reported elsewhere[22], both earnings and younger age are associated with a middle-, and higher-income status among the elderly. Conversely, advanced age, the loss of earnings from employment and simply being a minority elderly person, are strongly associated with poverty, marginal poverty and a lower-income status.

CHAPTER FOOTNOTES

INTRODUCTION

[1] The definition of 'minority' used in this report is based on race and Spanish origin as defined and reported by the U.S.Bureau of the Census in the 1980 Census and subsequent Current Population Surveys. The Hispanic elderly include all persons of all races reported to be of "Spanish Origin;" the Black elderly include all non-Hispanic persons whose race was reported as "Black;" and "other" minority elderly include all non-Hispanic persons whose race was reported as "other non-White." The minority elderly population is comprised of all Hispanic elderly, and all Black and other non-White elderly who are not Hispanic. The term 'non-minority' refers to non-Hispanic elderly whose race was reported as "White."

CHAPTER 1

[2] The 1980 Census is known to have undercounted members of minority populations due to problems encountered in enumeration. While the U.S.Bureau of the Census corrects, to the extent possible, for recognized undercounting, minority population figures reported in the 1980 Census may be significantly lower than actual population sizes.

[3] Data from 1980 Census and from the Current Population Survey are not directly comparable due to differences in methodology (i.e., full enumeration versus a sample survey, etc.) and populations (i.e., total population versus non-institutional population or, as reported here, household population). Wherever Census data is presented along with Current Population Survey data, it is done for information purposes only, and not for the analysis of any particular trend. Inferences beyond stated data can not be drawn with confidence from such comparisons.

[4] These study population estimates are subject to sampling variability as described in Appendix B. This variability or sampling error increases as the size of the population estimate decreases. While findings for the estimated 152,907 Hispanic elderly population are reported in full, data on this and other populations estimated at less than 200,000 must be interpreted with caution. No findings for "other" minority elderly, which are estimated at approximately 50,000, will be reported although data will be shown for information purposes. This "other" minority elderly population was excluded from analysis because of the large sampling error generally associated with population estimates of less than 90,000.

CHAPTER 2

[5] The findings presented here are based on an analysis of data for New York State from the Current Population Surveys conducted by U.S.Bureau of Census since the 1980 Census. The reported trends in the growth of the minority elderly population reflect a continuation of growth which occurred between 1970 and 1980. Based on data from the 1970 and 1980 Censuses, the Black population aged 60-plus increased by 35 percent from approximately 175,000 in 1970 to 237,000 in 1980; and the number of aged 60-plus of Spanish Origin increased by 53 percent from approximately 77,000 in 1970 to 117,000 in 1980. The reported trends are further evidenced in advanced data from the 1986 Current Population Survey (see Appendix D).

[6] The Current Population Survey population estimates for 1981 through 1984 were selected to establish population trend lines because of the comparability and internal consistency in Current Population Survey methodologies and sampling for these years. While only minor changes were introduced in the Current Population Surveys during these years, major changes were introduced in 1985 to update and improve the Current Population Survey sample for purposes of describing the population. These changes, to be completed with the 1986 Current Population Survey, made the 1985 population estimates of questionable comparability with prior estimates, particularly for the purposes of establishing trend lines for minority populations in New York State. Data from the 1980 Census was also not comparable and therefore not used to establish time trends.

[7] Note that the figures given here for the Black and Hispanic aged can not be summed with the figure for "other" minority elderly to obtain a total for the minority as a whole. Due to annual fluxuations in Current Population Survey population estimates for 1981 through 1984, the rate of growth in the number of Black and Hispanic aged, when computed separately on an AVERAGE ANNUAL BASIS, actually exceeded that for the minority elderly population as a whole. The projections presented assume continuation of the lower growth rate for the total minority elderly population and adjust separate Black and Hispanic aged projections downward (see footnote "[10]").

[8] Estimatetes of the current study population from the 1985 Current Population Survey are not directly v comparable to earlier years because of major changes in the survey sample (see footnote "[6]"). Nonetheless, the estimated 474,439 minority elderly in the study population is 12 percent t more than the estimated 422,597 in 1981, well within the expected continuation of the growth trtrend established from 1981 through 1984. The 1985 estimate of the Hispanic elderly populaticion similarly reflected continuation of the established growth trend and was 30 percent higher trthan the 1981 estimate of 117,640. The 1985 estimate of the Black elderly population was atypicaliily low (only 6 percent higher than the 1981 estimate of 255,763) but could be expected given thene nature of changes in the Current Population Survey sample, and can not be interpreted to reflecct a change in the 1981 to 1984 growth trend. (Also see Appendix D for preliminary study poccpulation estimates from the 1986 Current Population Survey.)

[9] Independcurent projections by the State Data Center of the New York State Department of Economic Developmeerent show the total aged 60-plus population of the State increasing from 3.0 million, as reported ' in the 1980 Census, to 3.4 million by 1990, and to 3.5 million by the year 2000. Reflectinng the aging of the post-World War II "baby boom" generation, the aged 60-plus populatiocon is then projected to jump to 4.1 million by 2010, beginning what has been called the "senior b.oom." Until then the younger elderly cohorts, those 60 to under 74 years old, are projecteed to decline; and, the older elderly are projected to continue to increase dramatically (e.g., thne aged 75-plus population is projected to increase by 12 percent between 1985 and 1990, and by ann additional 23 percent by the year 2000). The extent of recent declines in the younger non-minorrity elderly cohorts may be found in "Experimental County Estimates by Age, Sex, Race and Year:: New York State" prepared for the National Cancer Institute by the U.S.Bureau of the Census, Ffebruary 1987 (see the "Detailed Tables" section of this report).

[10] Projectiions are "straight line" linear projections of the 1985 Current Population Survey populatiion estimates: on an annual basis through 1990 assuming a growth rate equal to the average annual percent change in Current Population Survey population estimates for 1981 through 1984; and, on a five-year basis through 2000 assuming a moderating "middle" growth rate (approximately three-fourth of the average annual rate) and alternative "lower" and "higher" rates (approximately 25% lower and higher than the "middle" rate). All separate projections for the Black and the Hispanic aged were subsequently adjusted downwards not to exceed the projectiions of the minority elderly population as a whole. (See the projection tables in the "Detailed Tables" section for further information on the projections and assumed rates.)

CHAPTER 3

[11] Data from the 1980 and earlier Censuses presented here, are not available in a form that permits analysis for the minority elderly population as a whole, or for the Hispanic aged and other specific minority elderly populations. Also, the Black population is defined here by race onl', and includes persons identified as both Hispanic and Black.

[12] The Census data presented here is based on the definition of race as used by the U.S.Bureau of the Census, and includes the Hispanic population in White, Black and "Other Races" categories. The 1980 Census figure of 245,304 Black aged, for example, includes over 8,000 Hispanic aged as well as 237,277 Black non-Hispanic aged which is the figure cited elsewhere in this report.

[13] The migration trends presented here are further reflected in the overall mobility of the minority elderly including changes in residences within New York State. Overall 14 percent of the minority elderly, including 8 percent of the Black aged but 25 percent of the Hispanic aged, were living in a difference residence in 1985 than they had occupied in New York State in 1980--in comparison to 10 percent of the non-minority elderly. Stated differently, non-movers who neither changed residences nor migrated into New York State, comprised 83 percent of the minority elderly (only 69 percent of the Hispanic aged) in comparison to a larger 88 percent of the non-minority elderly.

[14] Life expectancy statistics are from the National Center for Health, and were available only by race, and then only selectively for the Black population and life expectancy at age 60 and age 65. Life expectancy statistics were not available separately for the Hispanic population. The unavailability of such statistics limits the ability of this, and obviously any report, to use life expectancy to assess and monitor the health status of the Hispanic population and its elderly members.

[15] The data on the leading causes of death of the aged 60-plus was provided by the Bureau of Vital Statistics of the New York State Department of Health. The minority elderly are again defined by race with comparisons limited to White versus all minority races.

CHAPTER 5

[16] The disparity in the residential distribution of the minority elderly may well have a significant impact on the political influence minority elderly can exert in New York State,

particularly at the local county government level. Indirectly, it is possible for such disparity to ultimately influence the distribution of existing resources and availability of services for the minority elderly.

[17] The estimates presented here are limited to the racial minority elderly population, exclusive of the Hispanic-White elderly population; and, were compiled from "Experimental County Estimates by Age, Sex, Race and Year: New York State," prepared for the National Cancer Institute by the U.S.Bureau of the Census, February 1987. Detailed county-by-county figures may be found in the table of estimates included in the "Detailed Tables" section of this report.

[18] Numerous studies have documented the inadequacies of minority housing in inner city poverty areas. See for example: "Black and Spanish Elderly: Their Housing Characteristics and Housing Quality" by S.Hoover (Journal of Minority Aging, March-October 1980, No. 5), and "Barriers to Adequate Housing for Elderly Blacks" by R.Johnson (Aging, September-October 1978).

CHAPTER 6

[19] Current employment statistics reported in the 1985 Current Population Survey for the month of March, showed 91,000 or 19 percent of the minority elderly household population in the labor force, either employed or officially recognized as unemployed (including 17 and 19 percent of the Black and Hispanic aged respectively). The reported unemployment rate for the minority elderly labor force was 5 percent, almost twice the 3 percent rate reported for the non-minority elderly.

In addition, an unknown number of the minority elderly: a) were active in the labor force but unreported because they worked part-time or seasonally; and, b) were "discouraged workers" who are chronically unemployed but not counted in official unemployment statistics. Elderly persons who lose their job often become discouraged from the inability to find appropriate employment in a youth oriented labor market, and stop seeking employment. They are no longer counted in official unemployment statistics and, as older persons, are "retired" even when able and desiring continued employment. This problem is particular severe for the minority elderly who face the double jeopardy of both age and race discrimination in the job market.

CHAPTER 8

[20] Because of the extensive sampling variability associated with small population estimates from the Current Population Survey, mean and median income figures are not shown if the number of recipients was reported at less than 90,000.

CHAPTER 9

[21] For example, in 1984, a person 65 years old with an income of $4,500 and a younger couple and child, with an income of $7,500 may or may not have be recognized as being below poverty. If living in separate family-units, all four persons would officially have been below poverty as the applicable thresholds were, respectively, $4,979 for a person 65-plus living alone, and $8,355 for a couple with a child under 18. If living together as one family-unit, their inadequate incomes would be hidden since the total of their income, i.e., $12,000, would be more than the $10,882 poverty threshold for a family-unit of four with a related child under 18. (See Appendix C for official poverty thresholds.)

[22] See "Economic Status of the Elderly: Income of Older New Yorkers" and "Economic Status of the Elderly: Sources of Income of Older New Yorker", New York State Office for the Aging.

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TABLE 1. Minority Populations* By Age -- New York State, 1980 Census

MINORITY POPULATION	Total Persons - All Ages		PERSONS AGED 60-PLUS		Aged 60+ As % Of Total Persons
	number	%	number	%	
ALL PERSONS	17,558,072	100.0	3,001,774	100.0	17 %
White Non-Minority	13,164,734	75.0	2,609,680	86.9	20 %
Minority	4,393,338	25.0	392,094	13.1	9 %
Black	2,299,127	13.1	237,277	7.9	10 %
Hispanic	1,659,300	9.5	117,431	3.9	7 %
Other	434,911	2.5	37,386	1.2	9 %
MINORITY POPULATION	4,393,338	100.0	392,094	100.0	9 %
Black	2,299,127	52.3	237,277	60.5	10 %
Hispanic	1,659,300	37.8	117,431	29.9	7 %
Other Minority	434,911	9.9	37,386	9.5	9 %
HISPANIC POPULATION BY NATIONAL ORIGIN AND RACE* - Total	1,659,300	100.0	117,431	100.0	7 %
Mexican	38,755	2.3	3,885	3.3	10 %
Puerto Rican	986,389	59.4	61,759	52.6	6 %
Cuban	76,942	4.6	13,237	11.3	17 %
Other Spanish	557,214	33.6	38,550	32.8	7 %
White	796,134	48.0	68,081	58.0	9 %
Black	102,879	6.2	8,027	6.8	8 %
Other	760,287	45.8	41,323	35.2	5 %
"OTHER" MINORITIES BY NATIONAL ORIGIN - Total	434,911	100.0	37,386	100.0	9 %
Amer.Ind./Eskimo/ Aleut - total	39,582	9.1	3,777	10.1	10 %
American Indian	38,967	9.0	3,724	10.0	10 %
Eskimo	330	0.1	27	0.1	8 %
Aleut	285	0.1	26	0.1	9 %
Asian/Pacific Islanders - total	310,526	71.4	26,673	71.3	9 %
Japanese	24,524	5.6	1,072	2.9	4 %
Chinese	148,105	34.1	17,527	46.9	12 %
Filipino	33,956	7.8	3,041	8.1	9 %
Korean	34,157	7.9	1,432	3.8	4 %
Asian/Indian	60,505	13.9	3,003	8.0	5 %
Vietnamese	6,644	1.5	202	0.5	3 %
Hawaiian	1,566	0.4	305	0.8	19 %
Guamanian	773	0.2	59	0.2	8 %
Samoan	296	0.1	32	0.1	11 %
Other**	84,803	19.5	6,936	18.6	8 %

* Minority populations are defined by race, i.e., "non-White", except for the Hispanic population. The Hispanic population is defined as all persons of Spanish Origin and may be of any race. Other minority populations include only non-Hispanic persons.

** Includes "non-White" persons of undesignated national origin.

Data Source: "1980 Census of Population: New York State," U.S. Bureau of the Census.

TABLE 2. Minority Household (Study) Population* By Age -- New York State, 1985 CPS

MINORITY POPULATION	Total Persons - All Ages		PERSONS AGED 60-PLUS		Aged 60+ As % Of Total Persons
	number	%	number	%	
ALL PERSONS	17,550,976	100	2,959,697	100	17 %
White Non-Minority	12,544,508	71	2,485,258	84	20 %
Minority	5,006,468	29	474,439	16	9 %
Black	2,461,777	14	270,047	9	11 %
Hispanic	2,061,440	12	152,907	5	7 %
Other	483,251	3	51,485	2	11 %
MINORITY POPULATION	5,006,468	100	474,439	100	9 %
Black	2,461,777	49	270,047	57	11 %
Other Minority	483,251	10	51,485	11	11 %

* The study population is limited to the household population of New York State, i.e., persons living in households only. Persons living in institutions or other group quarters are excluded.

Data Source: "1985 Current Population Survey (New York State)," U.S. Bureau of the Census.

TABLE 3. Change in the Minority Elderly Population* -- New York State, 1981 through 1984 CPS

YEAR and DATA SOURCE	Persons 60 Years Old and Over					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
NUMBER OF PERSONS AGED 60-PLUS						
1980 Census*	3,001,774	2,609,680	392,094	237,277	117,431	37,386
1981 CPS Estimate**	2,973,328	2,550,731	422,597	255,763	117,640	49,194
1982 CPS Estimate**	3,000,808	2,557,419	443,389	287,493	104,138	51,758
1983 CPS Estimate**	3,130,626	2,690,524	440,102	290,112	104,478	45,512
1984 CPS Estimate**	3,064,040	2,577,567	486,473	302,310	144,373	39,790
1985 CPS Study Population***	2,959,697	2,485,258	474,439	270,047	152,907	51,485
ANNUAL %-CHANGE IN COMPARABLE CPS ESTIMATES**						
1981-1982	+0.9	+0.3	+4.9	+12.4	-11.5B	b
1982-1983	+4.3	+5.2	-0.7	+0.9	+0.3B	b
1983-1984	-2.1	-4.2	+10.5	+4.2	+38.2B	b
Total Sum	+3.1	+1.3	+14.7	+17.5	+27.0B	b
Annual Average	+1.0	+0.4	+4.9	+5.8	+9.0B	b
3-YEAR %-CHANGE IN COMPARABLE CPS ESTIMATES**						
1981-1984 Total	+3.1	+1.1	+15.1	+18.2	+22.7B	b
1981-1984 Annualized	+1.0	+0.4	+5.0	+6.1	+7.6B	b

"B" = base of less than 200,000; "b"= base of less than 90,000.

* 1980 Census data includes person living in institutions and other group quarters. All CPS population estimates, including the estimates of the 1985 study population, are limited to the household population exclusive of persons in institutions and group quarters.

** Data from the 1981, 1982, 1983 and 1984 Current Population Surveys was based surveys of annual samples ('80 Census data was based on a full enumeration) drawn from a single sampling frame, and are comparable recognizing year-to-year sampling variability and limited definitional changes introduced by the Bureau of the Census.

*** With the 1985 CPS, the Bureau of the Census began converting to a new sampling frame to update and improve representation in the annual CPS survey sample. This convertion introduced major, basis changes in sampling for the 1985 CPS. Because of these changes, comparison of 1985 CPS to pre-1985 population estimates is not recommended.

Data Source: "1980 Census of the Population," "1981 Current Population Survey," "1982 Current Population Survey," "1983 Current Population Survey," "1984 Current Population Survey," and "1985 Current Population Survey," U.S. Bureau of the Census.

TABLE 4. Projections of the Minority Elderly Population* of New York State to the Year 2000

PROJECTION	Persons 60 Years Old and Over					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
1985 CPS Population Estimate	2,959,697	2,485,258	474,439	270,047	152,907	51,485
ANNUAL PROJECTIONS**						
1986	2,989,000	2,491,000	498,000	282,000	164,000	52,000
1987	3,019,000	2,497,000	522,000	294,000	177,000	51,000
1988	3,049,000	2,501,000	548,000	307,000	190,000	51,000
1989	3,080,000	2,505,000	575,000	320,000	204,000	51,000
1990	3,111,000	2,508,000	603,000	334,000	219,000	50,000
5-YEAR PROJECTIONS***						
Higher: 1995	3,321,000	2,527,000	794,000	423,000	322,000	49,000
2000	3,494,000	2,507,000	987,000	505,000	434,000	48,000
Middle: 1995	3,235,000	2,514,000	721,000	389,000	282,000	50,000
2000	3,365,000	2,502,000	863,000	452,000	362,000	49,000
Lower: 1995	3,179,000	2,526,000	653,000	358,000	245,000	50,000
2000	3,280,000	2,530,000	750,000	402,000	298,000	50,000
Assumed Annual Rate of Growth From 1985 to 1990**						
- Initial	+1.0%	NA	+4.9%	+5.8%	+9.0%	NA
- Actual	+1.0%	+0.2%	+4.9%	+4.3%	+7.4%	-0.6%
Assumed 5-Year Rate of Growth From 1990 to 2000***						
- Higher (initial)	+5.2%	NA	+24.4%	+29.2%	+45.2%	NA
- Middle: Initial	+4.0%	NA	+19.6%	+23.2%	+36.0%	NA
Actual	+4.0%	-0.1%	+19.6%	+16.3%	+28.6%	-1.0%
- Lower (initial)	+3.2%	NA	+14.8%	+17.6%	+27.2%	NA

Note: Projections for the "White Non-Minority" and "Other" populations may be misleading and should be interpreted with caution.

"NA"= not applicable, i.e., "White Non-Minority" and "Other" (due to the small N) populations were not projected separately.

* Household population exclusive of persons living in institutions or other group quarters.

** Projections are "straight line" linear projections of the 1985 CPS population estimate on an annual basis through 1990 assuming a growth rate (i.e., the "Initial" rate shown in the table) equal to the average annual percent change in CPS population estimates for 1981 through 1984. Resulting projections for the Black and Hispanic elderly were then adjusted downwards to equal the projections for the total minority elderly. These adjustments resulted in the "Actual" assumed growth rate shown in the table.

*** The "Middle" five-year projections are linear continuations of the annual projections given in the table, and assume a moderating growth rate beginning in 1990 which is shown in the table before (i.e., the "Initial" rate) and after (i.e., the "Actual" rate) adjustments. The "Higher" and "Lower" five-year projections are similarly extensions of annual projections (not shown) based on growth rates approximately 25 percent higher and lower, respectively, than the "Middle" series.

TABLE 5. Age Structure of the General Population by Race -- New York State, 1950 through 1980 Census

RACE AND AGE	1950	1960	1970	1980
ALL RACES - Total	14,830,192 (100)	16,782,304 (100)	18,236,967 (100)	17,558,072 (100)
Under 20 Years	4,255,964 (29)	5,720,633 (34)	6,440,601 (35)	5,325,435 (30)
20 To 29 Years	2,291,735 (15)	1,958,413 (12)	2,608,585 (14)	2,948,322 (17)
30 To 39 Years	2,363,179 (16)	2,376,797 (14)	2,065,903 (11)	2,458,746 (14)
40 To 49 Years	2,165,864 (15)	2,263,719 (13)	2,261,086 (12)	1,847,823 (11)
50 To 59 Years	1,810,308 (12)	1,966,696 (12)	2,037,878 (11)	1,975,972 (11)
60 To 69 Years	1,214,788 (8)	1,480,256 (9)	1,559,068 (9)	1,565,529 (9)
70 To 79 Years	672,815 (5)*	784,600 (5)	917,328 (5)	981,463 (6)
80 Years and Over	55,539 (<.5)*	231,190 (1)	346,518 (2)	454,782 (3)
Under 60 Years	12,887,050 (87)	14,2[illegible],258 (85)	15,414,053 (85)	14,556,298 (83)
under 30 years	6,547,699 (44)	7,6[illegible],046 (46)	9,049,186 (50)	8,273,757 (47)
30 to 59 years	6,339,351 (43)	6,607,212 (39)	6,364,867 (35)	6,282,541 (36)
60 Years and Over	1,943,142 (13)	2,496,046 (15)	2,822,914 (15)	3,001,774 (17)
WHITE - Total	13,872,095 (100)	15,287,071 (100)	15,834,090 (100)	13,960,868 (100)
Under 20 Years	3,968,421 (29)	5,160,058 (34)	5,431,786 (34)	3,955,432 (28)
20 To 29 Years	2,097,065 (15)	1,726,630 (11)	2,217,817 (14)	2,295,830 (16)
30 To 39 Years	2,173,908 (16)	2,120,724 (14)	1,730,776 (11)	1,909,921 (14)
40 To 49 Years	2,022,108 (15)	2,065,877 (14)	1,981,289 (13)	1,452,887 (10)
50 To 59 Years	1,726,779 (12)	1,829,495 (12)	1,845,100 (12)	1,669,037 (12)
60 To 69 Years	1,173,645 (8)	1,405,324 (9)	1,436,009 (9)	1,370,786 (10)
70 To 79 Years	656,107 (5)*	753,508 (5)	863,293 (5)	884,912 (6)
80 Years and Over	54,062 (<.5)*	223,455 (1)	328,020 (2)	422,063 (3)
Under 60 Years	11,988,281 (86)	12,904,784 (84)	13,206,768 (83)	11,283,107 (81)
under 30 years	6,065,486 (44)	6,888,688 (45)	7,649,603 (48)	6,251,262 (45)
30 to 59 years	5,922,795 (43)	6,016,096 (39)	5,557,165 (35)	5,031,845 (36)
60 Years and Over	1,883,814 (14)	2,382,287 (16)	2,627,322 (17)	2,677,761 (19)
BLACK - Total	919,675 (100)	1,414,184 (100)	2,168,949 (100)	2,402,006 (100)
Under 20 Years	278,410 (30)	534,410 (38)	922,491 (43)	903,152 (38)
20 To 29 Years	186,935 (20)	215,908 (15)	345,990 (16)	415,541 (17)
30 To 39 Years	181,800 (20)	242,019 (17)	296,002 (14)	349,655 (15)
40 To 49 Years	137,395 (15)	186,473 (13)	253,619 (12)	265,459 (11)
50 To 59 Years	77,910 (8)	129,115 (9)	175,798 (8)	222,895 (9)
60 To 69 Years	38,815 (4)	70,563 (5)	111,031 (5)	146,900 (6)
70 To 79 Years	16,900 (2)*	28,787 (2)	47,792 (2)	73,475 (3)
80 Years and Over	1,510 (<.5)*	6,909 (<.5)	16,226 (1)	24,929 (1)
Under 60 Years	862,450 (94)	1,307,925 (92)	1,993,900 (92)	2,156,702 (90)
under 30 years	465,345 (51)	750,318 (53)	1,268,481 (58)	1,318,693 (55)
30 to 59 years	397,105 (43)	557,607 (39)	725,419 (33)	838,009 (35)
60 Years and Over	57,225 (6)	106,259 (8)	175,049 (8)	245,304 (10)

Note: Figures given in parentheses are percentages of the total and may not sum to 100% due to rounding.

* In the 1950 Census: persons "80 To 84 Years" were included in the "75 To 79 Years" age category for the total, White, and Black populations; and, the age categories "75 To 79 Years," "80 To 84 Years," and "85 Years and Over" were not reported for "Other Races."

Data Source: "1950...," "1960...," "1970...," and "1980 Census of the Population." U.S. Bureau of the Census.

TABLE 6. Ten-Year Change In the Age Structure of the General Population by Race -- New York State, 1950 through 1980 Census

RACE AND AGE	Change In Population From:		
	1950-To-1960	1960-To-1970	1970-To-1980
ALL RACES - Total	1,952,112 (13.2)	1,454,663 (8.7)	-678,895 (-3.7)
Under 20 Years	1,464,669 (34.4)	719,968 (12.6)	-1,115,166 (-17.3)
20 To 29 Years	-333,322 (-14.5)	650,172 (33.2)	339,737 (13.0)
30 To 39 Years	13,618 (0.6)	-310,894 (-13.1)	392,843 (19.0)
40 To 49 Years	97,855 (4.5)	-2,633 (-0.1)	-413,263 (-18.3)
50 To 59 Years	156,388 (8.6)	71,182 (3.6)	-61,906 (-3.0)
60 To 69 Years	265,468 (21.9)	78,812 (5.3)	6,461 (0.4)
70 To 79 Years	111,785 (16.6)*	132,728 (16.9)	64,135 (7.0)
80 Years and Over	175,651 (316.3)*	115,328 (49.9)	108,264 (31.2)
Under 60 Years	1,399,208 (10.9)	1,127,795 (7.9)	-857,755 (-5.6)
under 30 years	1,131,347 (17.3)	1,370,140 (17.8)	-775,429 (-8.6)
30 to 59 years	267,861 (4.2)	-242,345 (-3.7)	-82,326 (-1.3)
60 Years and Over	552,904 (28.5)	326,868 (13.1)	178,860 (6.3)
WHITE - Total	1,414,976 (10.2)	547,019 (3.6)	-1,873,222 (-11.8)
Under 20 Years	1,191,637 (30.0)	271,728 (5.3)	-1,476,354 (-27.2)
20 To 29 Years	-368,435 (-17.6)	489,187 (28.3)	78,013 (3.5)
30 To 39 Years	-53,184 (-2.4)	-389,948 (-18.4)	179,145 (10.4)
40 To 49 Years	43,769 (2.2)	-84,588 (-4.1)	-528,402 (-26.7)
50 To 59 Years	102,716 (5.9)	15,605 (0.9)	-176,063 (-9.5)
60 To 69 Years	231,679 (19.7)	30,685 (2.2)	-65,223 (-4.5)
70 To 79 Years	97,401 (14.8)*	109,785 (14.6)	21,619 (2.5)
80 Years and Over	169,393 (313.3)*	104,565 (46.8)	94,043 (28.7)
Under 60 Years	916,503 (7.6)	301,984 (2.3)	-1,923,661 (-14.6)
under 30 years	823,202 (13.6)	760,915 (11.0)	-1,398,341 (-18.3)
30 to 59 years	93,301 (1.6)	-458,931 (-7.6)	-525,320 (-9.5)
60 Years and Over	498,473 (26.5)	245,035 (10.3)	50,439 (1.9)
BLACK - Total	494,509 (53.8)	754,765 (53.4)	233,057 (10.7)
Under 20 Years	256,000 (92.0)	388,081 (72.6)	-19,339 (-2.1)
20 To 29 Years	28,973 (15.5)	130,082 (60.2)	69,551 (20.1)
30 To 39 Years	60,219 (33.1)	53,983 (22.3)	53,653 (18.1)
40 To 49 Years	49,078 (35.7)	67,146 (36.0)	11,840 (4.7)
50 To 59 Years	51,205 (65.7)	46,683 (36.2)	47,097 (26.8)
60 To 69 Years	31,748 (81.8)	40,468 (57.4)	35,869 (32.3)
70 To 79 Years	11,887 (70.3)*	19,005 (66.0)	25,683 (53.7)
80 Years and Over	5,399 (357.5)*	9,317 (134.9)	8,703 (53.6)
Under 60 Years	445,475 (51.7)	685,975 (52.4)	162,802 (8.2)
under 30 years	284,973 (61.2)	518,163 (69.1)	50,212 (4.0)
30 to 59 years	160,502 (40.4)	167,812 (30.1)	112,590 (15.5)
60 Years and Over	49,034 (85.7)	68,790 (64.7)	70,255 (40.1)

Note: Ten-year percent change figures are given in parentheses.
* In the 1950 Census: persons "80 To 84 Years" were included in the "75 To 79 Years" age category for the total, White, and Black populations; and, the age categories "75 To 79 Years," "80 To 84 Years," and "85 Years and Over" were not reported for "Other Races."

Data Source: "1950...," "1960...," "1970...," and "1980 Census of the Population." U.S. Bureau of the Census.

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TABLE 7. Minority Elderly Persons* by PLACE OF RESIDENCE IN 1980 -- New York State, 1985 CPS

PLACE OF RESIDENCE IN 1980	Persons 60 Years Old and Over					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
Lived In SAME New York State Residence	2,586,239	2,193,171	393,068	247,098	105,283	40,687
Lived In DIFFERENT Residence - Total	373,458	292,087	81,371	22,949	47,624	10,798
In New York State	325,655	259,413	66,242	21,902	37,708	6,632
-- in same county	219,681	175,005	44,676	12,755	25,289	6,632
-- in different county	105,974	84,408	21,566	9,147	12,419	nr
In other state or abroad	47,803	32,674	15,129	1,047	9,916	4,166
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
Lived In SAME New York State Residence	87	88	83	92	69%	b
Lived In DIFFERENT Residence - Total	13	12	17	8	31%	b
In New York State	11	10	14	8	25%	b
-- in same county	7	7	9	5	17%	b
-- in different county	4	3	5	3	8%	b
In other state or abroad	2	1	3	<.5	6%	b
All Aged 60+ - Total	100%	84	16	9	5	2
Lived In SAME New York State Residence	100%	85	15	10	4	2
Lived In DIFFERENT Residence - Total	100%	78	22	6	13	3
In New York State	100%	80	20	7	12	2
-- in same county	100%	80	20	6	12	3
-- in different county	100%	80%	20%	9%	12%	---
In other state or abroad	b	b	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (CPS)," U.S.Bureau of the Census.

TABLE 8. Expectation of Life (In Years) At Selected Ages By Race and Sex -- United States, 1900-02 to 1984

AGE and YEAR	All Races			White			MINORITY RACES					
							Total			Black		
	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female
AT BIRTH:												
1984	74.7	71.1	78.3	75.3	71.8	78.8	71.3	67.3	75.2	69.7	65.5	73.7
1983	74.7	71.0	78.2	75.2	71.6	78.7	71.3	67.1	75.3	69.7	65.4	74.0
1982	74.5	70.9	78.1	75.1	71.5	78.7	71.0	66.8	75.0	69.4	65.1	73.7
1981	74.2	70.4	77.9	74.8	71.1	78.5	70.3	66.1	74.5	68.7	64.4	73.0
1980	73.7	70.0	77.5	74.4	70.7	78.1	69.5	65.3	73.6	68.0	63.7	72.3
1970	70.8	67.1	74.7	71.7	68.0	75.6	65.3	61.3	69.4	64.1	60.0	68.3
1900-02	49.2	na	na	na	48.2	51.1	na	na	na	na	32.5	35.0
AT AGE 65:												
1984	16.8	14.6	18.6	16.8	14.6	18.7	16.2	14.1	17.8	15.5	13.5	17.2
1983	16.7	14.5	18.6	16.8	14.5	18.7	16.2	14.1	17.9	15.5	13.4	17.3
1980	16.4	14.1	18.3	16.5	14.2	18.5	na	13.5	17.3	na	12.9	16.5
1970	15.2	13.1	17.0	15.2	13.1	17.1	14.9	12.9	16.4	na	na	na
1900-02	11.9	na	na	na	11.5	12.2	na	na	na	na	10.4	11.4
IN 1983:												
At Age 60	20.3	17.8	22.5	20.4	17.9	22.6	19.2	16.8	21.3	18.4	16.0	20.5
At Age 65	16.7	14.5	18.6	16.8	14.5	18.7	16.2	14.1	17.9	15.5	13.4	17.3
At Age 70	13.5	11.5	15.0	13.5	11.5	15.1	13.3	11.5	14.6	12.7	10.9	14.1
At Age 75	10.7	9.0	11.8	10.6	9.0	11.8	10.8	9.4	11.9	10.4	9.0	11.5
At Age 80	8.1	6.9	8.9	8.1	6.9	8.8	8.6	7.4	9.3	8.2	7.1	9.0
At Age 85	6.1	5.2	6.6	6.1	5.2	6.5	7.1	6.3	7.5	6.9	6.0	7.4

"na" = not available.

Data Source: National Center for Health Statistics.

TABLE 9. Differences Between RACES in Expectation of Life (in years) by Sex --United States, 1900-02 to 1984

AGE, YEAR and SEX	MINORITY RACES*					
	Total			Black		
	Both Sexes	Male	Female	Both Sexes	Male	Female
AT BIRTH: 1984	-4.0	-4.5	-3.6	-5.6	-6.3	-5.1
1983	-3.9	-4.5	-3.4	-5.5	-6.2	-4.7
1982	-4.1	-4.7	-3.7	-5.7	-6.4	-5.0
1981	-4.5	-5.0	-4.0	-6.1	-6.7	-5.5
1980	-4.9	-5.4	-4.5	-6.4	-7.0	-5.8
1970	-6.4	-6.7	-6.2	-7.6	-8.0	-7.3
1900-02	na	na	na	na	-15.7	-26.1
AT AGE 65: 1984	-0.6	-0.5	-0.9	-1.3	-1.1	-1.5
1983	-0.6	-0.4	-0.8	-1.3	-1.1	-1.4
1980	na	-0.7	-1.2	na	-1.3	-2.0
1970	-0.3	-0.2	-0.7	na	na	na
1900-02	na	na	na	na	-0.9	-0.8
IN 1983: At Age 60	-1.2	-1.1	-1.3	-2.0	-1.9	-2.1
At Age 65	-0.6	-0.4	-0.8	-1.3	-1.1	-1.4
At Age 70	-0.2	0.0	-0.5	-0.8	-0.6	-1.0
At Age 75	0.2	0.4	0.1	-0.2	0.0	-0.3
At Age 80	0.5	0.5	0.5	0.1	0.2	0.2
At Age 85	1.0	1.1	1.0	0.8	0.8	0.9

"na" = not available.

* Negative figures indicate a shorter life expectancy, and give the number of years by which the life of expectancy of the specified minority population is exceeded by the that of the respective White population.

Data Source: Based on life expectancy statistics from the National Center for Health Statistics.

TABLE 10. Differences Between SEXES in Expectation of Life (in years) by Race -- United States, 1900-02 to 1984

AGE and YEAR	All Races	White	MINORITY RACES	
			Total	Black
AT BIRTH:				
1984	7.2*	7.0	7.9	8.2
1983	7.2	7.1	8.2	8.6
1982	7.2	7.2	8.2	8.6
1981	7.5	7.4	8.4	8.6
1980	7.5	7.4	8.3	8.6
1970	7.6	7.6	8.1	8.3
1900-02	na	2.9	na	2.5
AT AGE 65:				
1984	4.0	4.1	3.7	3.7
1983	4.1	4.2	3.8	3.9
1980	4.2	4.3	3.8	3.6
1970	3.9	4.0	3.5	na
1900-02	na	0.7	na	1.0
IN 1983:				
At Age 60	4.7	4.7	4.5	4.5
At Age 65	4.1	4.2	3.8	3.9
At Age 70	3.5	3.6	3.1	3.2
At Age 75	2.8	2.8	2.5	2.5
At Age 80	2.0	1.9	1.9	1.9
At Age 85	1.4	1.3	1.2	1.4

"na" = not available.

* Positive figures indicate a longer life expectancy, and are the number of years by which the life expectancy of women exceed that of men for each specifed population.

Data Source: Based on life expectancy statistics from the National Center for Health Statistics.

TABLE 11. Number of Deaths of Persons Aged 60-Plus and Older from the FIVE LEADING CAUSES OF DEATH by Race -- New York State, 1984

CAUSE OF DEATH	Persons 60 Years and Over		
	All Races	White	BLACK AND OTHER
Number of Deaths			
All Causes - total deaths	133,186	120,493	12,693
FIVE LEADING CAUSES - total	109,847	99,590	10,257
Heart Diseases	64,180	58,684	5,496
Malignant Neoplasms	29,145	26,129	3,016
Cerebrovascular Disease	9,136	8,317	819
Pneumonia and Influenza	4,864	4,398	466
Diabetes Mellitus	2,522	2,062	460
Percentage			
All Causes - total deaths	100.0%	100.0%	100.0%
FIVE LEADING CAUSES - total	82.5	82.7	80.8
Heart Diseases	48.2	48.7	43.3
Malignant Neoplasms	21.9	21.7	23.8
Cerebrovascular Disease	6.9	6.9	6.5
Pneumonia and Influenza	3.7	3.7	3.7
Diabetes Mellitus	1.9	1.7	3.6
All Causes - total deaths	100.0%	90.5	9.5
FIVE LEADING CAUSES - total	100.0%	90.7	9.3
Heart Diseases	100.0%	91.4	8.6
Malignant Neoplasms	100.0%	89.7	10.3
Cerebrovascular Disease	100.0%	91.0	9.0
Pneumonia and Influenza	100.0%	90.4	9.6
Diabetes Mellitus	100.0%	81.8	18.2

Data Source: New York State Department of Health.

TABLE 12. Minority Elderly Persons In 1985 by Selected DEMOGRAPHIC Characteristics -- New York State, 1985 CPS

Selected DEMOGRAPHIC Characteristic	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
AGE						
60 To 64 Years	867,366	713,268	154,098	67,830	69,000	17,268
65 To 69 Years	716,058	575,543	140,515	81,948	39,373	19,194
70 To 74 Years	553,319	478,511	74,808	52,200	17,790	4,818
75 Years and Over	822,954	717,936	105,018	68,069	26,744	10,205
SEX						
Male	1,226,568	1,027,449	199,119	110,059	68,461	20,599
Female	1,733,129	1,457,809	275,320	159,988	84,446	30,886
MARITAL STATUS						
Currently Married	1,599,877	1,403,168	196,709	113,326	57,943	25,440
Widowed	951,938	773,787	178,151	101,797	55,515	20,839
Never Married	246,310	205,374	40,936	28,664	9,337	2,935
Divorced/Separated	161,572	102,929	58,643	26,260	30,112	2,271
- divorced	110,975	86,420	24,555	12,513	12,042	nr
- separated	50,597	16,509	34,088	13,747	18,070	2,271
LAST GRADE COMPLETED						
College	625,916	559,275	66,641	34,435	15,427	16,779
High School	1,457,471	1,291,982	165,489	106,480	47,012	11,997
Elementary School	876,310	634,001	242,309	129,132	90,468	22,709
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
AGE						
60 To 64 Years	29%	29%	32%	25%	45%	b
65 To 69 Years	24	23	30	30	26%	b
70 To 74 Years	19	19	16	19	12%	b
75 Years and Over	28	29	22	25	17%	b
SEX						
Male	41%	41%	42%	41%	45%	b
Female	59	59	58	59	55%	b
MARITAL STATUS						
Currently Married	54%	56%	41%	42%	38%	b
Widowed	32	31	38	38	36%	b
Never Married	8	8	9	11	6%	b
Divorced/Separated	5	4	12	10	20%	b
- divorced	4	3	5	5	8%	b
- separated	2	1	7	5	12%	b
LAST GRADE COMPLETED						
College	21%	23%	14%	13%	10%	b
High School	49	52	35	39	31%	b
Elementary School	30	26	51	48	59%	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 13. Minority Elderly Persons in 1985 by Selected HOUSEHOLD Characteristics -- New York State, 1985 CPS

Selected HOUSEHOLD Characteristic	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
TYPE OF HOUSEHOLD						
Living Alone	859,202	706,762	152,440	97,420	43,446	11,574
In Married Couple Family	1,715,367	1,487,754	227,613	120,252	69,582	37,779
In Other Households	385,128	290,742	94,386	52,375	39,879	2,132
- other family household	334,842	261,422	73,420	45,339	26,757	1,324
- non-family household	50,286	29,320	20,966	7,036	13,122	808
Family Household	2,050,209	1,749,176	301,033	165,591	96,339	39,103
Non-Family Household	909,488	736,082	173,406	104,456	56,568	12,382
SIZE OF HOUSEHOLD						
One Member (Alone)	859,202	706,762	152,440	97,420	43,446	11,574
Two Members	1,405,095	1,220,867	184,228	116,062	54,821	13,345
Three Members	385,714	337,765	47,949	23,906	19,563	4,480
Four or More Members	309,686	219,864	89,822	32,659	35,077	22,086
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
TYPE OF HOUSEHOLD						
Living Alone	29%	28%	32%	36%	28%	b
In Married Couple Family	58	60	48	45	46%	b
In Other Households	13	12	20	19	26%	b
- other family household	11	11	15	17	17%	b
- non-family household	2	1	4	3	9%	b
Family Household	69	70	63	61	63%	b
Non-Family Household	31	30	37	39	37%	b
SIZE OF HOUSEHOLD						
One Member (Alone)	29%	28%	32%	36%	28%	b
Two Members	47	49	39	43	36%	b
Three Members	13	14	10	9	13%	b
Four or More Members	10	9	19	12	23%	b

Note: Percentage distributions may not sum to 100% due to rounding.
"g" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 14. Minority Elderly Persons by AREA OF RESIDENCE -- New York State, 1985 CPS

AREA OF RESIDENCE	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
New York City	1,158,914	809,084	349,830	174,471	134,634	40,725
Rest of State	1,800,783	1,676,174	124,609	95,576	18,273	10,760
Central Cities	1,395,590	1,013,549	382,041	203,263	135,926	42,852
New York City	1,158,914	809,084	349,830	174,471	134,634	40,725
Other Central City	236,676	204,465	32,211	28,792	1,292	2,127
Outside Central Cities	1,564,107	1,471,709	92,398	66,784	16,981	8,633
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
New York City	39	33	74	65	888	b
Rest of State	61	67	26	35	128	b
Central Cities	47	41	81	75	898	b
New York City	39	33	74	65	888	b
Other Central City	8	8	7	11	18	b
Outside Central Cities	53	59	19	25	118	b
All Aged 60+ - Total	100%	84	16	9	5	2
New York City	100%	70	30	15	12	4
Rest of State	100%	93	7	5	1	1
Central Cities	100%	73	27	15	10	3
New York City	100%	70	30	15	12	4
Other Central City	100%	86	14	12	1	1
Outside Central Cities	100%	94	6	4	1	1

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (CPS)," U.S.Bureau of the Census.

TABLE 15. Aged 60-Plus Population of Counties by Sex and Race -- New York State, 1984 Estimates

COUNTY	Persons 60 Years Old and Over							AS % OF TOTAL 60+	
	Total All Races	White			BLACK AND OTHER			White	BLACK AND OTHER
		Total	Male	Female	TOTAL	Male	Female		
New York State	3,083,618	2,756,182	1,128,754	1,627,428	327,436	129,100	198,336	89.4	10.6
New York City	1,278,373	1,023,802	405,435	618,367	254,571	98,917	155,654	80.1	19.9
Bronx	194,227	148,024	56,696	91,328	46,203	17,055	29,148	76.2	23.8
Kings	375,752	298,337	121,244	177,093	77,415	29,083	48,332	79.4	20.6
New York	260,488	186,818	71,781	115,037	73,670	29,674	43,996	71.7	28.3
Queens	394,018	339,733	134,893	204,840	54,285	21,952	32,333	86.2	13.8
Richmond	53,888	50,890	20,821	30,069	2,998	1,153	1,845	94.4	5.6
Rest of State	1,805,245	1,732,380	723,319	1,009,061	72,865	30,183	42,682	96.0	4.0
Albany	54,604	52,618	20,550	32,068	1,986	810	1,176	96.4	3.6
Allegany	8,300	8,261	3,631	4,630	39	18	21	99.5	0.5
Broome	40,230	39,810	16,083	23,727	420	173	247	99.0	1.0
Cattaraugus	15,286	15,010	6,316	8,694	276	123	153	98.2	1.8
Cayuga	15,049	14,911	6,192	8,719	138	68	70	99.1	0.9
Chautauqua	29,377	29,071	12,051	17,020	306	153	153	99.0	1.0
Chemung	18,450	17,950	7,307	10,643	500	206	294	97.3	2.7
Chenango	8,969	8,892	3,896	4,996	77	36	41	99.1	0.9
Clinton	10,125	10,033	4,190	5,843	92	60	32	99.1	0.9
Columbia	13,035	12,744	5,556	7,188	291	123	168	97.8	2.2
Cortland	7,794	7,754	3,200	4,554	40	14	26	99.5	0.5
Delaware	9,761	9,691	4,217	5,474	70	35	35	99.3	0.7
Dutchess	39,450	37,563	15,663	21,900	1,887	866	1,021	95.2	4.8
Erie	188,982	175,942	71,871	104,071	13,040	5,624	7,416	93.1	6.9
Essex	7,659	7,627	3,206	4,421	32	13	19	99.6	0.4
Franklin	8,013	7,723	3,226	4,497	290	112	178	96.4	3.6
Fulton	11,786	11,689	4,954	6,735	97	41	56	99.2	0.8
Genesee	10,673	10,411	4,409	6,002	262	121	141	97.5	2.5
Greene	9,899	9,705	4,088	5,617	194	93	101	98.0	2.0
Hamilton	1,273	1,270	609	661	3	1	2	99.8	0.2
Herkimer	13,863	13,824	5,776	8,048	39	14	25	99.7	0.3
Jefferson	15,803	15,722	6,314	9,408	81	31	50	99.5	0.5
Lewis	4,143	4,119	1,848	2,271	24	13	11	99.4	0.6
Livingston	8,872	8,742	3,756	4,986	130	69	61	98.5	1.5
Madison	10,070	9,996	4,370	5,626	74	33	41	99.3	0.7
Monroe	112,682	107,426	42,767	64,659	5,256	2,318	2,938	95.3	4.7
Montgomery	12,970	12,909	5,310	7,599	61	26	35	99.5	0.5
Nassau	232,385	221,426	97,732	123,694	10,959	4,249	6,710	95.3	4.7
Niagara	41,115	39,670	16,576	23,094	1,445	726	719	96.5	3.5
Oneida	50,201	49,385	20,148	29,237	816	380	436	98.4	1.6
Onondaga	76,246	73,672	30,075	43,597	2,574	1,059	1,515	96.6	3.4
Ontario	15,594	15,351	6,829	8,522	243	112	131	98.4	1.6
Orange	40,545	38,638	16,247	22,391	1,907	848	1,059	95.3	4.7
Orleans	6,854	6,654	2,931	3,723	200	108	92	97.1	2.9
Oswego	17,047	16,966	7,370	9,596	81	28	53	99.5	0.5
Otsego	11,509	11,432	4,796	6,636	77	39	38	99.3	0.7
Putnam	10,567	10,494	4,537	5,957	73	27	46	99.3	0.7
Rensselaer	26,951	26,517	10,794	15,723	434	161	273	98.4	1.6
Rockland	33,260	31,347	12,906	18,441	1,913	791	1,122	94.2	5.8
St. Lawrence	17,837	17,736	7,470	10,266	101	28	73	99.4	0.6
Saratoga	22,406	22,078	9,528	12,550	328	127	201	98.5	1.5
Schenectady	31,492	30,894	12,290	18,604	598	265	333	98.1	1.9
Schoharie	5,569	5,525	2,416	3,109	44	18	26	99.2	0.8
Schuyler	3,240	3,227	1,448	1,779	13	7	6	99.6	0.4
Seneca	6,151	6,083	2,644	3,439	68	36	32	98.9	1.1
Steuben	18,926	18,708	8,288	10,420	218	112	106	98.8	1.2
Suffolk	182,707	174,448	72,708	101,740	8,259	3,505	4,754	95.5	4.5
Sullivan	14,415	13,889	6,348	7,541	526	223	303	96.4	3.6
Tioga	7,060	6,993	3,095	3,898	67	29	38	99.1	0.9
Tompkins	10,552	10,233	4,118	6,115	319	121	198	97.0	3.0
Ulster	28,957	28,239	11,884	16,355	718	315	403	97.5	2.5
Warren	10,269	10,215	4,164	6,051	54	21	33	99.5	0.5
Washington	9,769	9,738	4,057	5,681	31	14	17	99.7	0.3
Wayne	13,465	13,215	5,573	7,642	250	137	113	98.1	1.9
Westchester	161,959	147,190	60,262	86,928	14,769	5,475	9,294	90.9	9.1
Wyoming	6,580	6,540	2,828	3,712	40	17	23	99.4	0.6
Yates	4,499	4,464	1,901	2,563	35	11	24	99.2	0.8

Data Source: U.S. Bureau of the Census, "Experimental County Estimates by Age, Sex, Race and Year" (February 1987).

TABLE 16. Minority Elderly Persons in 1985 by TENURE and TYPE OF HOUSING -- NYS, 1985 CPS

TENURE and TYPE of HOUSING	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
HOUSING TENURE						
Owned (or Being Bought)	1,829,577	1,649,373	180,204	114,677	37,248	28,279
Rented	1,130,120	835,885	294,235	155,370	115,659	23,206
- no cash rent	26,132	23,938	2,194	1,096	1,098	nr
- cash rent	1,103,988	811,947	292,041	154,274	114,561	23,206
TYPE OF HOUSING						
House or Apartment	2,916,661	2,450,920	465,741	265,044	151,651	49,046
Rooming House, Hotel or Trailer	43,036	34,338	8,698	5,003	1,256	2,439
ELDERLY IN RENTED UNIT BY TYPE OF UNIT - tot	1,130,120	835,885	294,235	155,370	115,659	23,206
No Cash Rent	26,132	23,938	2,194	1,096	1,098	nr
Cash Rent	1,103,988	811,947	292,041	154,274	114,561	23,206
- public housing	150,232	92,645	57,587	37,029	20,558	nr
- rent subsidized	70,393	54,491	15,902	6,281	6,973	2,648
- other	883,363	664,811	218,552	110,964	87,030	20,558
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
HOUSING TENURE						
Owned (or Being Bought)	62%	66%	38%	42%	24%	b
Rented	38	34	62	58	76%	b
- no cash rent	1	1	<.5	<.5	1%	b
- cash rent	37	33	62	57	75%	b
TYPE OF HOUSING						
House or Apartment	99%	99%	98%	98%	99%	b
Rooming House, Hotel or Trailer	1	1	2	2	1%	b
ELDERLY IN RENTED UNIT BY TYPE OF UNIT - tot	100%	100%	100%	100%	100%	b
No Cash Rent	2	3	1	1	1%	b
Cash Rent	98	97	99	99	99%	b
- public housing	13	11	20	24	18%	b
- rent subsidized	6	7	5	4	6%	b
- other	78	80	74	71	75%	b
All Aged 60+ - Total	100%	84	16	9	5	2
HOUSING TENURE						
Owned (or Being Bought)	100%	90	10	6	2	2
Rented	100%	74	26	14	10	2
ELDERLY IN RENTED UNIT BY TYPE OF UNIT - tot	100%	74	26	14	10	2
No Cash Rent	b	b	b	b	b	b
Cash Rent	100%	74	26	14	10	2
- public housing	100%	62%	38%	25%	14%	nr
- rent subsidized	b	b	b	b	b	b
- other	100%	75	25	13	10	2

Note: Percentage distributions may not sum to 100% due to rounding.
"g" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.
Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 17. Minority Elderly Persons by Selected DWELLING UNIT Characteristics -- New York State, 1985 CPS

Selected DWELLING UNIT Characteristic	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
# OF DWELLING UNITS IN STRUCTURE						
Number of Units Known - total	2,445,510	2,038,236	407,274	231,070	135,710	40,494
One unit	1,221,367	1,125,628	95,739	59,380	20,419	15,940
2 to 9 units	567,622	431,722	135,900	82,030	43,330	10,540
10 or more	656,521	480,886	175,635	89,660	71,961	14,014
Unknown/Inappliable	514,187	447,022	67,165	38,977	17,197	10,991
TELEPHONE ACCESS						
No Phone In Unit	126,860	74,114	52,746	29,430	14,061	9,255
Telephone In Unit**	2,832,837	2,411,144	421,693	240,617	138,846	42,230
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
# OF DWELLING UNITS IN STRUCTURE						
Number of Units Known - total	83%	82%	86%	86%	89%	b
Unknown/Inappliable	17	18	14	14	11%	b
Number of Units Known - total	100%	100%	100%	100%	100%	b
One unit	50	55	24	26	15%	b
2 to 9 units	23	21	33	36	32%	b
10 or more	27	24	43	39	53%	b
TELEPHONE ACCESS						
No Phone In Unit	4%	3%	11%	11%	9%	b
Telephone In Unit**	96	97	89	89	91%	b
All Aged 60+ - Total	100%	84	16	9	5	2
# OF DWELLING UNITS IN STRUCTURE						
Number of Units Known - total	100%	83	17	9	6	2
One unit	100%	92	8	5	2	1
2 to 9 units	100%	76	24	14	8	2
10 or more	100%	73	27	14	11	2
Unknown/Inappliable	100%	87	13	8	3	2
TELEPHONE ACCESS						
No Phone In Unit	100%	58%	42%	23%	11%	7%
Telephone In Unit**	100%	85	15	8	5	1

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.
** Includes persons for whom questions of telephone availability were not asked or completed.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 18. Minority Elderly Persons In 1985 by EMPLOYMENT STATUS and REASON DID NOT WORK IN 1984 -- New York State, 1985 CPS

EMPLOYMENT and REASON DID NOT WORK IN 1984	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
EMPLOYMENT STATUS						
Employed In '84	732,318	613,467	118,851	64,835	36,427	17,589
Did Not Work	2,227,379	1,871,791	355,588	205,212	116,480	33,896
REASON DID NOT WORK						
IN 1984 - total	2,227,379	1,871,791	355,588	205,212	116,480	33,896
Retired	1,414,671	1,212,827	201,844	105,233	71,289	25,322
Taking Care of Home/ Family	513,155	438,827	74,328	39,961	27,920	6,447
Ill or Disabled	288,291	211,218	77,073	57,675	17,271	2,127
Other Reason/s	11,262	8,919	2,343	2,343	nr	nr
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
EMPLOYMENT STATUS						
Employed In '84	25	25	25	24	24%	b
Did Not Work	75	75	75	76	76%	b
-- retired	48	49	43	39	47%	b
-- taking care of home/family	17	18	16	15	18%	b
-- ill or disabled	10	8	16	21	11%	b
-- other reason/s	<.5	<.5	<.5	1	---	b
REASON DID NOT WORK						
IN 1984 - total	100%	100%	100%	100%	100%	b
Retired	64	65	57	51	61%	b
Taking Care of Home/ Family	23	23	21	19	24%	b
Ill or Disabled	13	11	22	28	15%	b
Other Reason/s	1	<.5	1	1	---	b
All Aged 60+ - Total	100%	84	16	9	5	2
EMPLOYMENT STATUS						
Employed In '84	100%	84	16	9	5	2
Did Not Work	100%	84	16	9	5	2
REASON DID NOT WORK						
IN 1984 - total	100%	84	16	9	5	2
Retired	100%	86	14	7	5	2
Taking Care of Home/ Family	100%	86	14	8	5	1
Ill or Disabled	100%	73	27	20	6	1
Other Reason/s	b	b	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 19. Minority Elderly Persons In 1985 By TYPE OF OCCUPATION At Which Employed In 1984 -- New York State, 1985 CPS

TYPE OF OCCUPATION	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
Employed In '84	732,318	613,467	118,851	64,835	36,427	17,589
Did Not Work	2,227,379	1,871,791	355,588	205,212	116,480	33,896
EMPLOYED IN '84 - Total	732,318	613,467	118,851	64,835	36,427	17,589
Professional	201,515	183,143	18,372	11,308	7,064	nr
- executive	89,177	78,702	10,475	6,065	4,410	nr
- specialist	107,237	99,340	7,897	5,243	2,654	nr
- technical	5,101	5,101	nr	nr	nr	nr
Sales/Admin.Support	217,037	193,750	23,287	15,465	5,395	2,427
- sales	80,249	72,464	7,785	7,785	nr	nr
- admin. support	136,788	121,286	15,502	7,680	5,395	2,427
Services	150,643	112,700	37,943	18,499	11,885	7,559
- household	10,147	5,113	5,034	5,034	nr	nr
- protective	17,290	12,043	5,247	4,042	1,205	nr
- transportation	21,241	18,765	2,476	1,539	937	nr
- other	101,965	76,779	25,186	7,884	9,743	7,559
Craft/Machine/Labor	141,312	105,826	35,486	17,834	12,083	5,569
- craft	62,599	48,095	14,504	7,073	4,160	3,271
- machine	70,564	52,383	18,181	8,961	6,922	2,298
- labor	8,149	5,348	2,801	1,800	1,001	nr
Farm	21,811	18,048	3,763	1,729	nr	2,034
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
Employed In '84	25	25	25	24	24B	b
Did Not Work	75	75	75	76	76B	b
EMPLOYED IN '84 - Total	100%	100%	100%	b	b	b
Professional	28	30	15B	b	b	b
Sales/Admin.Support	30	32	20B	b	b	b
Services	21	18	32B	b	b	b
Craft/Machine/Labor	19	17	30B	b	b	b
Farm	3	3	3B	b	b	b
All Aged 60+ - Total	100%	84	16	9	5	2
Employed In '84	100%	84	16	9	5	2
Did Not Work	100%	84	16	9	5	2
EMPLOYED IN '84 - Total	100%	84	16	9	5	2
Professional	100%	91	9	6	4	nr
Sales/Admin.Support	100%	89	11	7	2	1
Services	100%	75B	25B	12B	8B	5B
Craft/Machine/Labor	100%	75B	25B	13B	9B	4B
Farm	b	b	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 20. Minority Elderly Persons by CURRENT LABOR FORCE STATUS in March 1985 -- New York State, 1985 CPS

CURRENT LABOR FORCE STATUS	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 65+ - Total	2,999,697	2,485,258	474,439	270,047	152,907	51,485
Not In Labor Force	2,376,031	1,992,406	383,625	223,709	123,722	36,194
IN LABOR FORCE	583,666	492,852	90,814	46,338	29,185	15,291
Employed	563,936	478,028	85,908	43,522	27,095	15,291
Unemployed	19,730	14,824	4,906	2,816	2,090	nr
Labor Force Participation Rate	20%	20%	19%	17%	19%B	b
Unemployment Rate	3%	3%	5%B	b	b	b
Percentage						
All Aged 65+ - Total	100%	100%	100%	100%	100%	b
Not In Labor Force	80	80	81	83	81B	b
IN LABOR FORCE	20	20	19	17	19B	b
Employed	19	19	18	16	18B	b
Unemployed	1	1	1	1	1B	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 21. Minority Elderly Persons by Amount of PERSONAL INCOME IN 1985 --New York State, 1985 CPS

AMOUNT OF PERSONAL INCOME IN 1984	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
MEAN $s	$12,345	$13,117	$ 8,301	$ 8,254	$ 7,545	$10,796
MEDIAN $s	$ 7,794	$ 8,326	$ 5,600	$ 5,654	$ 5,362	$ 7,580
Under $2,000**	206,377	159,848	46,529	22,642	20,042	3,845
$2,000 to $3,999	324,314	244,022	80,292	47,455	22,668	10,169
$4,000 to $5,999	604,255	466,336	137,919	78,466	49,519	9,934
$6,000 to $7,999	384,519	334,187	50,332	34,236	13,825	2,271
$8,000 to $9,999	265,613	233,519	32,094	19,673	7,354	5,067
$10,000 to $12,499	234,470	205,507	28,963	15,947	9,421	3,595
$12,500 to $14,999	186,121	153,750	32,371	22,559	7,265	2,547
$15,000 to $19,999	273,557	248,562	24,995	6,077	12,464	6,454
$20,000 to $24,999	157,816	134,244	23,572	13,488	5,856	4,228
$25,000 or More	322,655	305,283	17,372	9,504	4,493	3,375

Under $6,000	1,134,946	870,206	264,740	148,563	92,229	23,948
$6,000 to $9,999	650,132	567,706	82,426	53,909	21,179	7,338
$10,000 to $14,999	420,591	359,257	61,334	38,506	16,686	6,142
$15,000 to $24,999	431,373	382,806	48,567	19,565	18,320	10,682
$25,000 or More	322,655	305,283	17,372	9,504	4,493	3,375

Under $10,000	1,785,078	1,437,912	347,166	202,472	113,400	31,286
$10,000 or More	1,174,619	1,047,346	127,273	67,575	39,499	20,199
$15,000 or More	754,028	688,089	65,939	29,069	22,813	14,057
$20,000 or More	480,471	439,527	40,944	22,992	10,349	7,603
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
Under $6,000	38	35	56	55	60B	b
Under $2,000	7	6	10	8	13B	b
$2,000 to $3,999	11	10	17	18	15B	b
$4,000 to $5,999	20	19	29	29	32B	b
$6,000 to $9,999	22	23	17	20	14B	b
$10,000 to $14,999	14	14	13	14	11B	b
$15,000 to $24,999	15	15	10	7	12B	b
$25,000 or More	11	12	4	4	3B	b

Under $10,000	60	58	73	75	74B	b
$10,000 or More	40	42	27	25	26B	b
$15,000 or More	25	28	14	11	15B	b
$20,000 or More	16	18	9	9	7B	b
All Aged 60+ - Total	100%	84	16	9	5	2
Under $6,000	100%	77	23	13	8	2
$6,000 to $9,999	100%	87	13	8	3	1
$10,000 to $14,999	100%	85	15	9	4	1
$15,000 to $24,999	100%	89	11	5	4	2
$25,000 or More	100%	95	5	3	1	1

Under $10,000	100%	81	19	11	6	2
$10,000 or More	100%	89	11	6	3	2
$15,000 or More	100%	91	9	4	3	2
$20,000 or More	100%	91	9	5	2	2

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.
** Includes persons reporting income losses and no income.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 22. 1984 AGGREGATE INCOME (In thousands of dollars) of Minority Elderly Persons by Amount of Personal Income In 1984 -- New York State, 1985 CPS

AMOUNT OF PERSONAL INCOME	Aggregate Income (in $000s) of Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Aggregate Income ($000s)						
All Aged 60+ - Total	$36,537,301	$32,598,865	$3,938,435	$2,228,907	$1,153,685	$555,842
- PER CAPITA In $s	$12,345	$13,117	$8,301	$8,254	$7,545	$10,796
Under $2,000	$ 96,547	$ 78,533	$ 18,014	$ 13,784	$ 3,017	$ 1,212
$2,000 to $3,999	1,002,789	748,174	254,615	154,361	67,597	32,657
$4,000 to $5,999	2,958,935	2,290,982	667,953	382,368	236,100	49,485
$6,000 to $7,999	2,644,579	2,309,506	335,072	227,025	90,965	17,082
$8,000 to $9,999	2,372,882	2,088,971	283,911	171,366	67,882	44,662
$10,000 to $12,499	2,627,042	2,311,410	315,632	174,248	104,677	36,707
$12,500 to $14,999	2,529,020	2,084,340	444,680	314,617	97,448	32,614
$15,000 to $19,999	4,735,477	4,299,375	436,102	99,079	215,843	121,180
$20,000 to $24,999	3,532,396	3,009,734	522,663	292,972	127,490	102,201
$25,000 or More	14,037,634	13,377,840	659,794	399,087	142,664	118,043
Under $6,000	$ 4,058,271	$ 3,117,689	$ 940,582	$ 550,513	$ 306,714	$ 83,354
$6,000 to $9,999	5,017,461	4,398,477	618,983	398,391	158,847	61,744
$10,000 to $14,999	5,156,062	4,395,750	760,312	488,865	202,125	69,321
$15,000 to $24,999	8,267,873	7,309,109	958,765	392,051	343,333	223,381
$25,000 or More	14,037,634	13,377,840	659,794	399,087	142,664	118,043
Under $10,000	$ 9,075,732	$ 7,516,166	$1,559,565	$ 948,904	$ 465,561	$145,098
$10,000 or More	27,461,569	25,082,699	2,378,871	1,280,003	688,122	410,745
$15,000 or More	22,305,507	20,686,949	1,618,559	791,138	485,997	341,424
$20,000 or More	17,570,030	16,387,574	1,182,457	692,059	270,154	220,244
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
Under $6,000	11	10	24	25	27B	b
under $2,000	<.5	<.5	<.5	1	<.5B	b
$2,000 to $3,999	3	2	6	7	6B	b
$4,000 to $5,999	8	7	17	17	20B	b
$6,000 to $9,999	14	13	16	18	14B	b
$10,000 to $14,999	14	13	19	22	18B	b
$15,000 to $24,999	23	22	24	18	30B	b
$25,000 or More	38	41	17	18	12B	b
Under $10,000	25	23	40	43	40B	b
$10,000 or More	75	77	60	57	60B	b
$15,000 or More	61	63	41	35	42B	b
$20,000 or More	48	50	30	31	23B	b
All Aged 60+ - Total	100%	89	11	6	3	2
Under $6,000	100%	77	23	14	8	2
$6,000 to $9,999	100%	88	12	8	3	1
$10,000 to $14,999	100%	85	15	9	4	1
$15,000 to $24,999	100%	88	12	5	4	3
$25,000 or More	100%	95	5	3	1	1
Under $10,000	100%	83	17	10	5	2
$10,000 or More	100%	91	9	5	3	1
$15,000 or More	100%	93	7	4	2	2
$20,000 or More	100%	93	7	4	2	1

Note: Distributions may not sum to totals due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

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TABLE 23. Percentage Distribution of Total Elderly Population* and Total 1984 Aggregate Income of the Elderly by Race/Ethnicity and Amount of Personal Income in 1984 -- New York State, 1985 CPS

AMOUNT OF PERSONAL INCOME	Aggregate Income (in $000s) of Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
% OF ELDERLY PERSONS						
All Aged 60+ - Total	100%	84	16	9	5	2
Under $2,000	7	5	2	1	1	<.5
$2,000 to $3,999	11	8	3	2	1	<.5
$4,000 to $5,999	20	16	5	3	2	<.5
$6,000 to $7,999	13	11	2	1	<.5	<.5
$8,000 to $9,999	9	8	1	1	<.5	<.5
$10,000 to $12,499	8	7	1	1	<.5	<.5
$12,500 to $14,999	6	5	1	1	<.5	<.5
$15,000 to $19,999	9	8	1	<.5	<.5	<.5
$20,000 to $24,999	5	5	1	<.5	<.5	<.5
$25,000 or More	11	10	1	<.5	<.5	<.5

Under $6,000	38	29	9	5	3	1
$6,000 to $9,999	22	19	3	2	1	<.5
$10,000 to $14,999	14	12	2	1	1	<.5
$15,000 to $24,999	15	13	2	1	1	<.5
$25,000 or More	11	10	1	<.5	<.5	<.5

Under $10,000	60	49	12	7	4	1
$10,000 or More	40	35	4	2	1	1
$15,000 or More	25	23	2	1	1	<.5
$20,000 or More	16	15	1	1	<.5	<.5
% OF AGGREGATE INCOME						
All Aged 60+ - Total	100%	89	11	6	3	2
Under $2,000	<.5	<.5	<.5	<.5	<.5	<.5
$2,000 to $3,999	3	2	1	<.5	<.5	<.5
$4,000 to $5,999	8	6	2	1	1	<.5
$6,000 to $7,999	7	6	1	1	<.5	<.5
$8,000 to $9,999	6	6	1	<.5	<.5	<.5
$10,000 to $12,499	7	6	1	<.5	<.5	<.5
$12,500 to $14,999	7	6	1	1	<.5	<.5
$15,000 to $19,999	13	12	1	<.5	1	<.5
$20,000 to $24,999	10	8	1	1	<.5	<.5
$25,000 or More	38	37	2	1	<.5	<.5

Under $6,000	11	9	3	2	1	<.5
$6,000 to $9,999	14	12	2	1	<.5	<.5
$10,000 to $14,999	14	12	2	1	1	<.5
$15,000 to $24,999	23	20	3	1	1	1
$25,000 or More	38	37	2	1	<.5	<.5

Under $10,000	25	21	4	3	1	<.5
$10,000 or More	75	69	7	4	2	1
$15,000 or More	61	57	4	2	1	1
$20,000 or More	48	45	3	2	1	1

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 24. 1984 Aggregate Income (in thousands of dollars) of Minority Elderly Persons by SOURCE OF INCOME -- New York State, 1985 CPS

INCOME SOURCE	Aggregate Income (in $000s) of Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY TOTAL	Black	Hispanic	Other
Aggregate Income ($000s)						
All Sources - Total	$36,537,301	$32,598,865	$3,938,435	$2,228,907	$1,153,685	$555,842
Social Security Income	10,806,602	9,400,584	1,406,018	836,146	389,983	179,888
Property Income	7,224,321	6,903,396	320,925	130,995	82,783	107,147
Interest	5,619,647	5,367,207	252,441	90,784	57,823	103,834
Other Property Income	1,604,674	1,536,189	68,484	40,211	24,960	3,313
Earnings	13,058,300	11,580,617	1,477,683	797,899	480,677	199,107
Pension Income	4,627,511	4,140,647	486,865	324,439	99,997	62,428
Supplemental Security Income	372,883	191,280	181,604	98,196	76,593	6,815
Other Sources	447,683	382,341	65,341	41,232	23,652	457
Per Capita in $s						
All Sources - Total	$12,345	$13,117	$8,301	$8,254	$7,545	$10,796
Social Security Income	3,651	3,783	2,964	3,096	2,550	3,494
Property Income	2,441	2,778	676	485	541	2,081
Interest	1,899	2,160	532	336	378	2,017
Other Property Income	542	618	144	149	163	64
Earnings	4,412	4,660	3,115	2,955	3,144	3,867
Pension Income	1,564	1,666	1,026	1,201	654	1,213
Supplemental Security Income	126	77	383	364	501	132
Other Sources	151	154	138	153	155	9
Percentage						
All Sources - Total	100%	100%	100%	100%	100%	b
Social Security Income	30	29	36	38	34B	b
Property Income	20	21	8	6	7B	b
Interest	15	16	6	4	5B	b
Other Property Income	4	5	2	2	2B	b
Earnings	36	36	38	36	42B	b
Pension Income	13	13	12	15	9B	b
Supplemental Security Income	1	1	5	4	7B	b
Other Sources	1	1	2	2	2B	b
All Sources - Total	100%	89	11	6	3	2
Social Security Income	100%	87	13	8	4	2
Property Income	100%	96	4	2	1	1
Interest	100%	96	4	2	1	2
Other Property Income	100%	96	4	3	2	<.5
Earnings	100%	89	11	6	4	2
Pension Income	100%	89	11	7	2	1
Supplemental Security Income	100%	51B	49B	26B	21B	2B
Other Sources	100%	85	15	9	5	<.5

Note: Distributions may not sum to totals due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 25. Minority Elderly Persons in 1985 by SOURCES OF INCOME in 1984 -- New York State, 1985 CPS

INCOME SOURCE	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 65+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
With Social Security	2,169,910	1,859,435	310,475	187,580	87,171	35,724
Only Social Security	433,639	321,403	112,236	72,152	32,030	8,054
With Property Income	1,914,686	1,751,454	163,232	92,301	42,390	28,541
Interest	1,870,387	1,716,832	153,555	82,624	42,390	28,541
Other Property Income	550,514	517,225	33,289	21,580	8,867	2,842
With Earnings	730,712	611,861	118,851	64,835	36,427	17,589
With Pension Income	837,261	757,619	79,642	44,164	28,824	6,654
With SSI Income	161,026	94,349	66,677	40,905	23,645	2,127
Percentage						
All Aged 65+ - Total	100%	100%	100%	100%	100%	b
With Social Security	73	75	65	69	57B	b
Only Social Security	15	13	24	27	21B	b
With Property Income	65	70	34	34	28B	b
Interest	63	69	32	31	28B	b
Other Property Income	19	21	7	8	6B	b
With Earnings	25	25	25	24	24B	b
With Pension Income	28	30	17	16	19B	b
With SSI Income	5	4	14	15	15B	b
All Aged 65+ - Total	100%	84	16	9	5	2
With Social Security	100%	86	14	9	4	2
Only Social Security	100%	74	26	17	7	2
With Property Income	100%	91	9	5	2	1
Interest	100%	92	8	4	2	2
Other Property Income	100%	94	6	4	2	1
With Earnings	100%	84	16	9	5	2
With Pension Income	100%	90	10	5	3	1
With SSI Income	100%	59B	41B	25B	15B	1B

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 26. Percentage Distribution of Total Elderly Population* and Total 1984 Aggregate Income of the Elderly by Race/Ethnicity, and by Sources of Income in 1984 -- New York State, 1985 CPS

INCOME SOURCE	Aggregate Income (in $000s) of Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
% of Elderly Persons With Income Source						
All Aged 65+ - Total	100%	84	16	9	5	2
With Social Security	73	63	10	6	3	1
Only Social Security	15	11	4	2	1	<.5
With Property Income	65	59	6	3	1	1
Interest	63	58	5	3	1	1
Other Property Income	19	17	1	1	<.5	<.5
With Earnings	25	21	4	2	1	1
With Pension Income	28	26	3	1	1	<.5
With SSI Income	5	3	2	1	1	<.5
% of Aggregate Income						
All Sources - Total	100%	89	11	6	3	2
Social Security Income	30	26	4	2	1	<.5
Property Income	20	19	1	<.5	<.5	<.5
Interest	15	15	1	<.5	<.5	<.5
Other Property Income	4	4	<.5	<.5	<.5	<.5
Earnings	36	32	4	2	1	1
Pension Income	13	11	1	1	<.5	<.5
Supplemental Security Income	1	1	<.5	<.5	<.5	<.5
Other Sources	1	1	<.5	<.5	<.5	<.5

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 27. 1984 MEAN and MEDIAN INCOME (in dollars) of Minority Elderly Persons from Selected Sources of Income -- New York State, 1985 CPS

INCOME SOURCE	$s Per Recipient 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY TOTAL	Black	Hispanic	Other
MEAN Income (in $s) From Specified Source						
All Sources - Total	$12,345	$13,117	$ 8,301	$ 8,254	$ 7,545B	b
Social Security Income	4,980	5,056	4,529	4,458B	b	b
Property Income	3,773	3,942	1,966B	1,419B	b	b
Interest	3,005	3,126	1,644B	b	b	b
Other Property Income	2,915	2,970	b	b	b	b
Earnings	17,871	18,927	12,433B	b	b	b
Pension Income	5,527	5,465	b	b	b	b
SSI Income	2,316B	2,027B	b	b	b	b
MEDIAN Income (in $s) From Specified Source						
All Sources - Total	$ 7,794	$ 8,326	$ 5,600	$ 5,654	$ 5,362B	b
Social Security Income	4,908	4,994	4,396	4,330B	b	b
Property Income	1,054	1,155	<250B	<250B	b	b
Interest	844	932	<250B	b	b	b
Other Property Income	1,025	1,005	b	b	b	b
Earnings	14,112	15,328	11,128B	b	b	b
Pension Income	3,678	3,644	b	b	b	b
SSI Income	2,034B	1,856B	b	b	b	b

"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 28. Minority Elderly Persons by Amount of SOCIAL SECURITY INCOME* In 1984 -- New York State, 1985 CPS

AMOUNT OF SOCIAL SECURITY INCOME	Persons 60 Years Old and Over**					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No Social Security	789,787	625,823	163,964	82,467	65,736	15,761
With Social Security	2,169,910	1,859,435	310,475	187,580	87,171	35,724
WITH SOCIAL SECURITY INCOME - Total	2,169,910	1,859,435	310,475	187,580	87,171	35,724
Under $2,000	140,500	118,815	21,685	12,857	4,403	4,425
$2,000 to $3,999	580,959	470,208	110,751	70,784	28,851	11,116
$4,000 to $5,999	799,985	685,050	114,935	61,360	41,070	12,505
$6,000 to $7,999	451,892	410,136	41,756	33,309	8,447	nr
$8,000 or More	196,574	175,226	21,348	9,270	4,400	7,678
MEDIAN In $s	$4,908	$4,994	$4,396	$4,330B	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No Social Security	27	25	35	31	43B	b
With Social Security	73	75	65	69	57B	b
WITH SOCIAL SECURITY INCOME - Total	100%	100%	100%	100%	b	b
Under $2,000	6	6	7	7B	b	b
$2,000 to $3,999	27	25	36	38B	b	b
$4,000 to $5,999	37	37	37	33B	b	b
$6,000 to $7,999	21	22	13	18B	b	b
$8,000 or More	9	9	7	5B	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Includes Railroad Retirement income.
** Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 29. Minority Elderly Persons by Amount of TOTAL PROPERTY INCOME* In 1984 -- New York State, 1985 CPS

TOTAL AMOUNT OF PROPERTY INCOME	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No Property Income	1,045,011	733,804	311,207	177,746	110,517	22,944
With Property Income	1,914,686	1,751,454	163,232	92,301	42,390	28,541
WITH PROPERTY INCOME - Total	1,914,686	1,751,454	163,232	92,301	42,390	28,541
Under $250**	607,943	514,703	93,240	55,519	25,619	12,102
$250 to $999	332,581	316,374	16,207	10,502	3,775	1,930
$1,000 to $2,499	320,984	289,345	31,639	18,188	3,247	10,204
$2,500 to $4,999	247,978	238,757	9,221	3,669	5,552	nr
$5,000 or More	405,200	392,275	12,925	4,423	4,197	4,305
MEDIAN In $s	$1,054	$1,155	<$250B	<$250B	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No Property Income	35	30	66	66	72B	b
With Property Income	65	70	34	34	28B	b
WITH PROPERTY INCOME - Total	100%	100%	100%	100%	b	b
Under $250**	32	29	57B	60B	b	b
$250 to $999	17	18	10B	11B	b	b
$1,000 to $2,499	17	17	19B	20B	b	b
$2,500 to $4,999	13	14	6B	4B	b	b
$5,000 or More	21	22	8B	5B	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.
** Includes a total of less than 18,000 persons with property income losses.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 30. Minority Elderly Persons by Amount of INTEREST INCOME In 1984
-- New York State, 1985 CPS

AMOUNT OF INTEREST INCOME	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No Interest Income	1,089,310	768,426	320,884	187,423	110,517	22,944
With Interest Income	1,870,387	1,716,832	153,555	82,624	42,390	28,541
WITH INTEREST INCOME - Total	1,870,387	1,716,832	153,555	82,624	42,390	28,541
Under $250	646,183	549,463	96,720	56,211	28,407	12,102
$250 to $999	348,060	333,247	14,813	9,068	3,007	2,738
$1,000 to $2,499	323,786	296,428	27,358	12,922	5,040	9,396
$2,500 to $4,999	230,224	224,663	5,561	1,816	3,745	nr
$5,000 or More	322,134	313,031	9,103	2,607	2,191	4,305
MEDIAN In $s	$844	$932	<$250B	$ b	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No Interest Income	37	31	68	69	72B	b
With Interest Income	63	69	32	31	28B	b
WITH INTEREST INCOME - Total	100%	100%	100%	b	b	b
Under $250	35	32	63B	b	b	b
$250 to $999	19	19	10B	b	b	b
$1,000 to $2,499	17	17	18B	b	b	b
$2,500 to $4,999	12	13	4B	b	b	b
$5,000 or More	17	18	6B	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 31. Minority Elderly Persons by Amount of "OTHER"* PROPERTY INCOME in 1984 -- New York State, 1985 CPS

AMOUNT OF "OTHER"* PROPERTY INCOME	Persons 60 Years Old and Over**					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No "Other" Property Income	2,409,183	1,968,033	441,150	248,467	144,040	48,643
With "Other" Property Income	550,514	517,225	33,289	21,580	8,867	2,842
WITH "OTHER"* PROPERTY INCOME - Total	550,514	517,225	33,289	21,580	8,867	2,842
Under $250***	159,116	147,768	11,348	9,395	1,953	nr
$250 to $999	112,869	110,141	2,728	nr	1,920	808
$1,000 to $2,499	128,392	118,719	9,673	6,700	939	2,034
$2,500 to $4,999	67,456	60,913	6,543	3,669	2,874	nr
$5,000 or More	82,681	79,684	2,997	1,816	1,181	nr
MEDIAN In $s	$1,025	$1,005	$ b	$ b	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No "Other" Property Income	81	79	93	92	94%	b
With "Other" Property Income	19	21	7	8	6%	b
WITH "OTHER"* PROPERTY INCOME - Total	100%	100%	b	b	b	b
Under $250***	29	29	b	b	b	b
$250 to $999	21	21	b	b	b	b
$1,000 to $2,499	23	23	b	b	b	b
$2,500 to $4,999	12	12	b	b	b	b
$5,000 or More	15	15	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* "Other" property income includes income from dividends, rents, royalties, estates and trusts.
** Household population exclusive of persons living in institutions or other group quarters.
*** Includes a total of approximate 24,000 persons with losses of "other" property income.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 32. Minority Elderly Persons by Amount of Income from EARNINGS* In 1984 -- New York State, 1985 CPS

AMOUNT OF EARNINGS* INCOME	Persons 60 Years Old and Over**					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No Earnings	2,228,985	1,873,397	355,588	205,212	116,480	33,896
With Earnings	730,712	611,861	118,851	64,835	36,427	17,589
WITH EARNINGS* - Total	730,712	611,861	118,851	64,835	36,427	17,589
Under $2,000***	69,242	57,298	11,944	8,569	nr	3,375
$2,000 to $5,999	127,055	110,758	16,297	7,109	7,864	1,324
$6,000 to $9,999	93,891	72,183	21,708	13,700	5,368	2,640
$10,000 to $14,999	85,071	57,944	27,127	13,912	9,620	3,595
$15,000 to $19,999	113,030	95,797	17,233	8,259	6,547	2,427
$20,000 to $24,999	69,068	52,557	16,511	8,607	3,676	4,228
$25,000 to $29,999	46,421	43,043	3,378	1,272	2,106	nr
$30,000 or More	126,934	122,281	4,653	3,407	1,246	nr
Under $10,000	290,188	240,239	49,949	29,378	13,232	7,339
$10,000 to $19,999	198,101	153,741	44,360	22,171	16,167	6,022
$20,000 to $29,999	115,489	95,600	19,889	9,879	5,782	4,228
$30,000 or More	126,934	122,281	4,653	3,407	1,246	nr
MEDIAN In $s	$14,112	$15,328	$11,1288	$ b	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No Earnings	75	75	75	76	76B	b
With Earnings	25	25	25	24	24B	b
WITH EARNINGS* - Total	100%	100%	100%	b	b	b
Under $2,000***	9	9	10B	b	b	b
$2,000 to $5,999	17	18	14B	b	b	b
$6,000 to $9,999	13	12	18B	b	b	b
$10,000 to $14,999	12	9	23B	b	b	b
$15,000 to $19,999	15	16	14B	b	b	b
$20,000 to $24,999	9	9	14B	b	b	b
$25,000 to $29,999	6	7	3B	b	b	b
$30,000 or More	17	20	4B	b	b	b
Under $10,000	40	39	42B	b	b	b
$10,000 to $19,999	27	25	37B	b	b	b
$20,000 to $29,999	16	16	17B	b	b	b
$30,000 or More	17	20	4B	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Earnings include income from wages, salary and self-employment.
** Household population exclusive of persons living in institutions or other group quarters.
*** Includes a total of approximately 14,000 persons with losses of net earnings related to self-employment.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 33. Minority Elderly Persons by Amount of Income from PENSIONS* in 1984 -- New York State, 1985 CPS

AMOUNT OF PENSION* INCOME	Persons 60 Years Old and Over**					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No Pension Income	2,122,436	1,727,639	394,797	225,883	124,083	44,831
With Pension Income	837,261	757,619	79,642	44,164	28,824	6,654
WITH PENSION*						
INCOME - Total	837,261	757,619	79,642	44,164	28,824	6,654
Under $4,000	446,792	408,006	38,786	16,464	18,765	3,557
Under $2,000	271,225	243,563	27,662	12,485	14,167	1,010
$2,000 to $3,999	175,567	164,443	11,124	3,979	4,598	2,547
$4,000 to $7,999	211,212	190,118	21,094	14,343	6,751	nr
$8,000 or More	179,257	159,495	19,762	13,357	3,308	3,097
MEDIAN In $s	$3,678	$3,644	$ b	$ b	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No Pension Income	72	70	83	84	818	b
With Pension Income	28	30	17	16	198	b
WITH PENSION*						
INCOME - Total	100%	100%	b	b	b	b
Under $4,000	53	54	b	b	b	b
Under $2,000	32	32	b	b	b	b
$2,000 to $3,999	21	22	b	b	b	b
$4,000 to $7,999	25	25	b	b	b	b
$8,000 or More	21	21	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Includes income from annuities and retirement accounts as well as public (state/local, federal and military) and private pension/retirement funds or systems.
** Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 34. Minority Elderly Persons by Amount of SUPPLEMENTAL SECURITY INCOME (SSI) In 1984 -- New York State, 1985 CPS

AMOUNT OF SSI INCOME	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
No SSI Income	2,798,671	2,390,909	407,762	229,142	129,262	49,358
With SSI Income	161,026	94,349	66,677	40,905	23,645	2,127
WITH SSI INCOME - Total	161,026	94,349	66,677	40,905	23,645	2,127
Under $2,000	79,705	50,826	28,879	20,708	8,171	nr
$2,000 to $3,999	46,299	28,443	17,856	11,383	4,346	2,127
$4,000 or More	35,022	15,080	19,942	8,814	11,128	nr
MEDIAN In $s	$2,034B	$1,856B	$ b	$ b	$ b	$ b
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
No SSI Income	95	96	86	85	85B	b
With SSI Income	5	4	14	15	15B	b
WITH SSI INCOME - Total	100%	100%	b	b	b	b
Under $2,000	49B	54B	b	b	b	b
$2,000 to $3,999	29B	30B	b	b	b	b
$4,000 or More	22B	16B	b	b	b	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

TABLE 35. Minority Elderly Persons by POVERTY AND INCOME STATUS IN 1984 -- New York State, 1985 CPS

POVERTY STATUS	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
Number						
All Aged 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
BELOW OR IN MARGINAL POVERTY	790,888	586,120	204,768	122,512	71,706	10,550
Below Poverty (<100%**)	331,206	210,000	121,206	68,755	48,894	3,557
In Marginal (100-149%) Poverty	459,682	376,120	83,562	53,757	22,812	6,993
ABOVE MARGINAL POVERTY	2,168,809	1,899,138	269,505	147,535	81,201	40,935
Lower Income (150-249%)	654,831	562,504	92,327	57,430	26,179	8,718
Middle Income (250-499%)	935,352	811,834	123,352	62,910	43,118	17,490
Higher Income (500%+)	578,626	524,800	53,826	27,195	11,904	14,727
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
BELOW OR IN MARGINAL POVERTY - total	27%	24%	43%	45%	47%	b
Below Poverty (<100%**)	11	8	26	25	32%	b
In Marginal (100-149%) Poverty	16	15	18	20	15%	b
ABOVE MARGINAL POVERTY	73%	76%	57%	55%	53%	b
Lower Income (150-249%)	22	23	19	21	17%	b
Middle Income (250-499%)	32	33	26	23	28%	b
Higher Income (500%+)	20	21	11	10	8%	b
All Aged 60+ - Total	100%	84	16	9	5	2
BELOW OR IN MARGINAL POVERTY	100%	74	26	15	9	1
Below Poverty (<100%**)	100%	63	37	21	15	1
In Marginal (100-149%) Poverty	100%	82	18	12	5	2
ABOVE MARGINAL POVERTY	100%	88	12	7	4	2
Lower Income (150-249%)	100%	86	14	9	4	1
Middle Income (250-499%)	100%	87	13	7	5	2
Higher Income (500%+)	100%	91	9	5	2	3

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000.
* Household population exclusive of persons living in institutions or other group quarters.
** The figures in parentheses are percentages of the official federal poverty thresholds (see Appendix D) used to define poverty and each of the income status levels shown.

Data Source: "1985 Current Population Survey (New York State)," U.S.Bureau of the Census.

Appendices

A. DEFINITIONS

B. LIMITATIONS OF CURRENT POPULATION SURVEY DATA

C. POVERTY AND INCOME STATUS MATRICES

D. STUDY POPULATION ESTIMATES FROM THE 1986 CPS

E. RECIPIENCY OF SELECTED ENTITLEMENTS AND BENEFITS REPORTED IN THE 1985 CPS

APPENDIX A. Definitions

Aggregate Income -- The algebraic sum of the amount of income received by a population, subpopulation or group, from all or specified sources.

Balance of SMSA -- See "Standard Metropolitan Statistical Area."

Central City -- See "Standard Metropolitan Statistical Area."

Dwelling Unit -- Same as "housing unit"; see "Household."

Earnings -- Earnings are income from money wages or salary, and net income from farm and nonfarm self-employment: Money wages or salary is total money earnings received for work performed as an employee during the income year, and includes wages, salary, commissions, tips, piece-rate payments, and cash bonuses earned, before deductions were made for taxes, bonds, pensions, union dues or others; Net income from nonfarm self-employment is net money income (gross receipts minus expenses) including losses from one's own business, professional enterprise, or partnership; Net income from farm self-employment is net money income (gross receipts minus operating expenses) including losses from the operation of a farm by a person on his own account, as an owner, renter or sharecropper.

Family -- The term "family" refers to a group of two or more persons related by birth, marriage, or adoption who reside together in a household, and include among their numbers the person designated as the householder. All persons in the group are considered members of one family. Every family must include a householder.

Family Household -- A family household is a household consisting of a family, which by definition includes the householder, and any other persons residing in the household who are not related to the family.

Family-Unit -- "Family-units" are defined as families, unrelated subfamilies, and unrelated individuals who are not members of unrelated subfamilies, and are specifically recognized for purposes of determining poverty rates (also see Appendix C). While families always live in their own households, unrelated individuals may either be living in the household of another or be householders of their own households. Members of unrelated subfamilies are unrelated individuals, but for purposes of measuring poverty are treated as a family-unit. Other unrelated individuals are always "one person family-units" while families and unrelated subfamilies are always family-units of two or more persons.

Family-Unit Income -- The algebraic sum of the amount of income received by the person or persons who comprise the family-unit.

Group Quarters -- All persons who are not members of households are regarded as living in group quarters. Group quarters are living arrangements for groups containing five or more persons unrelated to the person in charge, such as residents of lodging and boarding homes, persons living in military barracks, and inmates of institutions.

Hispanic -- See "Spanish Origin."

Household -- A household consists of all the persons who occupy a housing unit. A house, an apartment or other group of rooms, or a single room, is regarded as a housing unit, when it is occupied or intended for occupancy as separate living quarters; that is, when the occupants do not live and eat with any other persons in the structure and there is either (1) direct access from the outside or through a common hall or (2) a kitchen or cooking equipment for the exclusive use of the occupants.

A household includes the related family members and all unrelated persons, if any, such as lodgers, foster children, friends, wards, or employees who share the housing unit. A person living alone in a housing unit is also counted as a household. The count of households excludes group quarters.

Household Income -- The algebraic sum of the amount of income received by the person or persons who comprise the household, i.e., are members of the household whether or not they are related to the householder.

Householder -- The householder is the adult designated as the person (or one of the persons) in whose name the home is owned or rented. If the home is owned or rented jointly by a married

couple, either the husband or the wife may be designated as the householder. One person in each household is designated as the householder. The number of householders, therefore, is equal to the number of households.

Housing Unit -- See "Household."

Income (also see definitions of specific sources) -- Income is the total money income before payments for personal income taxes and other deductions received by persons 15 years of age and older during the preceding calendar year from each of the following sources: (1) money wages or salary; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security or railroad retirement; (5) Supplemental Security Income; (6) public assistance or welfare payments; (7) interest on savings or other investments which pay interest; (8) dividends, income from estates or trusts, or net rental income; (9) veteran's payments or unemployment and worker's compensation; (10) private pensions or government employee pensions; (11) alimony or child support, regular contributions from persons not living in the household, and other periodic income.

Income does not include receipts of money from: capital gains, withdrawals of bank deposits, money borrowed, tax refunds, gifts, or lump-sum inheritances or insurance payments.

Income Status Level -- See "Appendix C."

Married Couple Family -- A family in which the householder is currently married and residing with his or her spouse.

Mean Income -- Mean income is the amount obtained by dividing the number of persons who receive income from a source(s), i.e., recipients, into the total amount of income they receive from that source(s).

Median Income -- Median income is the amount which divides a distribution into two equal groups, one having incomes above the median, and the other having incomes below the median. Only persons who receive income from a source(s), i.e., recipients, are included in the distribution.

Movers -- As used in the current report, "movers" were identified in the 1985 CPS on the basis of a comparison of each person's place of residence at the time of the March 1985 CPS and the person's place of residence five years earlier in 1980. Nonmovers are all persons who were living in the same housing unit at the beginning and end of the period. Movers are all persons who were living in different housing units at the beginning and end of the period.

"Other" Income Sources -- "Other" sources of income as used in this report includes: alimony and child support; contributions received periodically from persons not living in the household; other periodic income such as military family allotments and net gambling winnings; unemployment compensation from government agencies and private organizations including strike benefits from unions; veterans' payments made by the Veterans Administration; worker's compensation received periodically from public or private insurance companies when the cost of the insurance was paid by the employer and not by the person; and, public assistance payments under programs such as Home Relief and Emergency Assistance to Adults.

Non-Family Household -- A non-family household is a household in which the householder is not related to any other person who may be residing in the household. Non-family households include one-person households, i.e., households in which the householder lives alone.

Pension Income -- Pension income is income from private and government employee pensions or retirement funds, and periodic receipts from annuities, and from private accounts including Individual Retirement Accounts (IRAs) established as retirement accounts and recognized as such by the Internal Revenue Service. Private and government employee pensions include: private pensions or retirement benefits paid to a retired person or his survivors by a former employer or by a union, either directly or through an insurance company; and, government employee pensions received from retirement pensions paid by Federal, State, county or other governmental agencies to former employees or their survivors.

Per Capita Income -- Per capita income is the amount obtained by dividing the aggregate income of a population, subpopulation or group from all or specified sources by the total number of persons, both recipients and non-recipients, in the population, subpopulation or group.

Personal Income -- The algebraic sum of the amount of income received by the individual from money wages and salaries, net income from self-employment, and income other than earnings. Also see "Income."

Poverty -- See Appendix C.

Poverty Threshold -- See Appendix C.

Property Income -- Property income is money income from personal and real property, and includes: interest on savings or any type of investment which pays interest; dividends from stockholdings or membership in associations; periodic receipts from estates or trust funds; and, net income (including losses) from rental of a house, store or other property to others, from boarders or lodgers, and from royalties.

Public Housing -- See Appendix E.

Race -- The population is divided in the Current Population Survey into three groups on the basis of race: White, Black, and "other races." Persons of Spanish Origin can be of any race. "Minority," as used in the current report, is defined by both race and Spanish Origin, while the term "racial minority" is reserved for use in referring to the non-White population defined by race only, i.e., Black and "other race" populations inclusive of persons of Spanish Origin.

Recipient -- A person who receives income of any amount (or has income losses) from a source(s) is referred to as a "recipient." A person who receives zero income from a source(s) is referred to as a "non-recipient."

Rent Subsidy -- See Appendix E.

Social Security Income -- Social Security income includes: Social Security pensions and survivor's benefits, and permanent disability insurance payments made by the Social Security Administration prior to deductions for medical insurance; and railroad retirement insurance checks from the U.S. Government. Medicare health insurance reimbursements are not included. (Health insurance reimbursements, whether Medicare or private, e.g., Blue Cross/Blue Shield, are treated as other insurance reimbursements for losses, such home and car insurance reimbursements, which are not included in total money income.)

Spanish Origin -- The population is divided in the Current Population Survey into persons of Spanish Origin and persons not of Spanish Origin. Persons of Spanish Origin can be of any race.

Standard Metropolitan Statistical Area (SMSA) -- SMSAs are defined as counties or groups of contiguous counties which contain at least one city of 50,000 inhabitants or more, or twin cities with a combined population of at least 50,000. The city or cities around which the SMSA is formed is referred to as a "Central City/ies." The area outside the Central City/ies, but within the county/ies which comprise an SMSA, is referred to as the "Balance of the SMSA." The area of the State constituted by counties not defined as being part of any SMSA is referred to as "Outside SMSAs."

Supplemental Security Income -- Supplemental Security Income is money income from payments made by the Federal and State government under the Supplemental Security Income (SSI) program for low income persons who are aged (65 years old or over), blind, or disabled.

Tenure -- A housing unit may be either "owner occupied" or "renter occupied." It is "owner occupied" if the householder living in the unit is the owner or co-owner. All members of the household are then referred to as living in an owner occupied housing unit even though they themselves may be neither owner nor co-owner.

All other occupied housing units are defined as "renter occupied," including units rented for cash rent and those occupied without payment of cash rent. While the householder is the person or one of the persons in whose name the unit is rented, all persons in the household are referred to as living in renter occupied units.

Unrelated Individual -- The term "unrelated individual" refers to persons 15 years old and over who are not residing as members of a family. An unrelated individual may (1) being living alone constituting a one-person household; (2) be the householder of a larger household which includes other unrelated individuals; (3) be a member of a larger household which includes a family or one or more other unrelated individuals; or (4) reside in non-institutional group quarters such as a rooming house.

In categorizing persons below and above the poverty level, unrelated individuals are defined as "one person family-units" irrespective of their living arrangements or status as householders, except for members of unrelated subfamilies who are recognized as members of family-units of two or more persons.

Unrelated Subfamily -- An unrelated subfamily is a married couple with or without children, or one parent with one or more single children under 18 years old who are living in a household, but are not related to the householder who maintains the household. Because the unrelated subfamily does not include a householder, it is by definition excluded from the count of families, and all members of the unrelated subfamily are included in the count of unrelated individuals. However, unrelated subfamilies are treated as family-units of two or more persons for the purpose of determining whether their members are above or below the poverty level (also see Appendix C).

APPENDIX B. Limitations of Current Population Survey Data

The current report on "Minority Elderly New Yorkers" is based in part on data for the aged 60 and older household population of New York State from the March 1985 Current Population Survey (CPS), U.S.Bureau of the Census. Data from the 1985 CPS was collected by the Bureau of the Census for a household probability sample, representative of New York State's non-institutional population. Except for persons living in non-institutional group quarters, who were excluded from data presented in the current report, the sample was representative of the household population of New York State. Members of the Armed Forces were included only if they lived off base, or with families in separate housing units on base.

The CPS is primarily designed to collect employment and related economic data on households, 'family-units,' and persons living in households. It also collects selected demographic and housing information necessary for identifying various subpopulations.

All information from the 1985 CPS describing the characteristics, including age, of the population refers to the population as of March 1985. All information on income, including poverty and income status, which is reported in the 1985 CPS is for 1984, i.e., the twelve months prior to the time of the interview.

All information collected in the CPS is reported for persons 15 years of age and older. Characteristics such as age, race and sex are collected and reported in the CPS for persons of all ages. However, children under 15 years old who are unrelated individuals are excluded from the CPS unless members of unrelated subfamilies.

PUBLIC USE COMPUTER TAPES

The data in the current report was obtained by processing the 1985 CPS public use computer tape which was issued by the Bureau of the Census and made available to the New York State Office for the Aging by the State Data Center, New York State Department of Economic Development.

SAMPLING VARIABILITY

The Current Population Survey is conducted annually by the U.S. Bureau of the Census using a household probability sample representative of the nation, states and larger Standard Metropolitan Statistical Areas (SMSAs). With the 1985 CPS, the Bureau of the Census updated approximately half of the CPS sampling frame based on the 1980 Census and revised SMSA definitions.

The CPS data used in the current report is subject to sampling variability which may cause a) reported estimates of the population to be higher or lower than the actual number that would be determined in a full enumeration, and b) differences between reported percentages due solely to the random chance drawing of the sample. Both of these types of sampling variability are measured in terms of standard errors which are calculable using statistical formulas, and constants for national data published by the Bureau of the Census.

While standard errors are not generally reported for CPS data, analysis and interpretation of the data must take into consideration the underlying variability inherent in the CPS sample. The variability associated with the New York State component of the CPS sample is larger than that for the full national sample. Preliminary analysis found that because of the large standard errors involved, distributions based on estimated populations of less than 90,000 did not reveal useful information.

All distributions (i.e., numbers, percentages, means, medians and aggregate income figures) used in the analysis reported in the current report are based on estimated populations of at less 90,000, and with rare exception, at less 200,000 or more. Where used, distributions based on 90,000 to less than 200,000 are so noted and are subject to greater sampling variability than those of 200,000 and more.

Distributions based on population estimates of less than 90,000, while excluded from the analysis, are presented (except for computed figures, i.e., percentages, means, etc.) in tables and must be interpreted with caution due to sampling error.

The absolute numbers, and aggregate income figures, of all population estimates, irrespective of size, are subject to sampling variability, and must be interpreted with caution. Caution must also be exercised in comparing population estimates and summary measures from the 1985 CPS for New York State to estimates and measures from other sources and from prior Current Population Surveys.

Because of the changes in the sampling frame and revised SMSA definitions introduced with the 1985 CPS, selected items reported in the CPS were identified by the Bureau of the Census as exceptionally vulnerable to sampling error. Data for these items were excluded from the analysis and findings presented in the current report.

NON-SAMPLING ERROR

Data from the Current Population Survey is subject to non-sampling error from a variety of sources including errors of underreporting, nonreporting or misreporting. These errors may occur due to such factors as failure to report income received from unusual sources, reluctance to report certain types of income, rounding estimates, and interviewer errors.

Underreporting and nonreporting of income is known to be more severe for some than other kinds of income. Underreporting tends to be more pronounced for income sources that are not derived from earnings, such as Social Security, income from interest and dividends, and other sources. Nonresponses on survey items regarding income are particularly high. In order that the maximum amount of information can be utilized, the Bureau of the Census imputes or allocates missing income items by values which are obtained from survey respondents with similar economic and demographic characteristics.

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For further information on sampling and non-sampling sources of variability, and other information on the 1985 Current Population Survey see "Characteristics of the Population Below the Poverty Level: 1984," (Current Population Reports, Series P-60) or related publications of the U.S. Bureau of the Census.

APPENDIX C. Poverty and Income Status Matrices

Poverty and "income status" are defined in the current report based on the official federal definition of poverty used by the U.S.Bureau of the Census to statistically measure the prevalence of poverty. This statistical definition consists of a matrix of 48 poverty thresholds for family-units of different size and composite. (These thresholds should not be confused with the separate simplified sets of poverty levels for the current year which are issued annually for use in determining the income eligibility of applicants under certain federal programs.)

The official statistical poverty thresholds for 1984 which were used by the Bureau of the Census in the 1985 Current Population Survey (CPS) are shown in Table C-1. The 48 thresholds are arrayed in a two-dimensional table by the size of the family-unit, and by the number of related children under 18 in the family-unit. Separate thresholds are used for one person family-units under 65 years of age and 65-plus, and for two person family-units with householders under 65 and 65-plus.

The family-unit is classified below the poverty level if its total money income for the prior year is less than the respective threshold amount. In the 1985 CPS, for example, based on the income thresholds given in Table C-1, an elderly person living alone, i.e., a one person family-unit aged 65-plus, was below the poverty level if her/his income in 1984 was less than $5,400. A four person family-unit consisting of a married couple and their two children under 18 years of age, was classified below the poverty level if their total family-unit income, i.e., the sum of the income of all persons in the family-unit, was less than $10,527 in 1984.

Persons below the poverty level based on the official thresholds given in Table C-1 are identified in the current report as "below-poverty." In addition, four other "income status" groups are identified based on multiples of the official thresholds. Family-units were classified as:

"Marginal-poverty" if their 1984 incomes were at least 100% of the thresholds in Table C-1, but less than the 150% cutoffs given in Table C-2;

"Lower-income" if their incomes were at least equal to the 150% amounts in Table C-2, but less than the 250% cutoffs given in Table C-3;

"Middle-income" if their incomes were at least equal to the 250% amounts in Table C-3, but less than the 500% cutoffs given in Table C-4; and,

"Higher-income" if their family-unit incomes were equal to or more than the 500% amounts given in Table C-4.

The poverty and income status of persons was determined by the status of their family-units, i.e., all persons in a family-unit were assigned the poverty and income status of their family-unit.

It is important to note that the use of the official poverty thresholds and multiples thereof, to measure "income status," provides a RELATIVE measure of income status and in no way is intended as an ABSOLUTE measure of income adequacy. The official poverty definition and thresholds have come under severe criticism as an absolute measure of poverty. While the exclusion of non-cash assistance from prior year income has been heavily criticized, the amounts of the thresholds have been more seriously criticized as being outdated (they were last recalibated in the mid-1960s) and as being two or more times below the actual amount of income required for a family-unit to maintain a subsistance, non-poverty standard of living (see "Census and Designation of Poverty and Income," Joint Congressional Hearing Before the Subcommittee On Census and Population and the Subcommittee on Oversight, May 15, 1984).

The particular multiples of the 100% poverty thresholds used to define other income status levels and to measure the relative income status of groups were selected after a preliminary analysis of more detailed multiples reported by the Bureau of the Census in the 1984 Current Population Survey. These detailed distributions for persons aged 65-plus in New York State were published in "Economic Status of the Elderly: Income of Older New Yorkers" (New York State Office for the Aging). Final selection of the 150%, 250% and 500% cutoffs was based on a requirement that each income status group or level include a sufficient base population estimate to permit meaningful analysis using the CPS sample for New York State.

TABLE C-1. POVERTY (100%) THRESHOLD MATRIX by Size of Family-Unit and Number of Related Children Under 18 Years Old -- Total Money Income In Dollars In 1984

SIZE OF FAMILY-UNIT	Number of Related Children Under 18 Years Old								
	None	One	Two	Three	Four	Five	Six	Seven	Eight Or More
One Person:									
Under 65 years.....	$ 5,400								
65 years and over..	4,979								
Two Persons:									
Householder under 65 years.....	6,951	$ 7,155							
Householder 65-plus	6,275	7,128							
Three Persons.....	8,120	8,355	$ 8,363						
Four Persons.....	10,707	10,882	10,527	$10,564					
Five Persons.....	12,912	13,100	12,699	12,388	$12,199				
Six Persons.....	14,851	14,910	14,603	14,308	13,871	$13,611			
Seven Persons.....	17,088	17,195	16,827	16,571	16,093	15,536	$14,925		
Eight Persons.....	19,112	19,281	18,933	18,629	18,198	17,650	17,080	$16,935	
Nine Persons or More.	22,990	23,102	22,794	22,536	22,113	21,530	21,003	20,873	$20,069

TABLE C-2. 150% "MARGINAL-POVERTY" Income Cutoffs by Size of Family-Unit and Number of Related Children Under 18 Years Old -- Total Money Income In Dollars In 1984

SIZE OF FAMILY-UNIT	Number of Related Children Under 18 Years Old								
	None	One	Two	Three	Four	Five	Six	Seven	Eight Or More
One Person:									
Under 65 years.....	$ 8,100								
65 years and over..	7,469								
Two Persons:									
Householder under 65 years.....	10,427	$10,733							
Householder 65-plus	9,413	10,692							
Three Persons.....	12,180	12,533	$12,545						
Four Persons.....	16,061	16,323	15,791	$15,846					
Five Persons.....	19,368	19,650	19,049	18,582	$18,299				
Six Persons.....	22,277	22,365	21,905	21,462	20,807	$20,417			
Seven Persons.....	25,632	25,793	25,241	24,857	24,140	23,304	$22,388		
Eight Persons.....	28,668	28,922	28,400	27,944	27,297	26,475	25,620	$25,403	
Nine Persons or More.	34,485	34,653	34,191	33,804	33,170	32,295	31,505	31,310	$30,104

TABLE C-3. 250% "LOWER-INCOME" Status Cutoffs by Size of Family-Unit and Number of Related Children Under 18 Years Old -- Total Money Income In Dollars In 1984

SIZE OF FAMILY-UNIT	Number of Related Children Under 18 Years Old								
	None	One	Two	Three	Four	Five	Six	Seven	Eight Or More
One Person:									
Under 65 years.....	$13,500								
65 years and over..	12,448								
Two Persons:									
Householder under 65 years.....	17,378	$17,888							
Householder 65-plus	15,688	17,820							
Three Persons.....	20,300	20,888	$20,908						
Four Persons.....	26,768	27,205	26,318	$26,410					
Five Persons.....	32,280	32,750	31,748	30,970	$30,498				
Six Persons.....	37,128	37,275	36,508	35,770	34,678	$34,028			
Seven Persons.....	42,720	42,988	42,068	41,428	40,233	38,840	$37,313		
Eight Persons.....	47,780	48,203	47,333	46,573	45,495	44,125	42,700	$42,338	
Nine Persons or More.	57,475	57,755	56,985	56,340	55,283	53,825	52,508	52,183	$50,173

TABLE C-4. 500% "MIDDLE-INCOME" Status Cutoffs by Size of Family-Unit and Number of Related Children Under 18 Years Old -- Total Money Income In Dollars In 1984

SIZE OF FAMILY-UNIT	Number of Related Children Under 18 Years Old								
	None	One	Two	Three	Four	Five	Six	Seven	Eight Or More
One Person:									
Under 65 years.....	$27,000								
65 years and over..	24,895								
Two Persons:									
Householder under 65 years.....	34,755	$35,775							
Householder 65-plus	31,375	35,640							
Three Persons.....	40,600	41,775	$41,815						
Four Persons.....	53,535	54,410	52,635	$52,820					
Five Persons.....	64,560	65,500	63,495	61,940	$60,995				
Six Persons.....	74,255	74,550	73,015	71,540	69,355	$68,055			
Seven Persons.....	85,440	85,975	84,135	82,855	80,465	77,680	$74,625		
Eight Persons.....	95,560	96,405	94,665	93,145	90,990	88,250	85,400	$84,675	
Nine Persons or More.	114,950	115,510	113,970	112,680	110,565	107,650	105,015	104,365	$100,345

APPENDIX D. Study Population Estimates from the 1986 CPS

TABLE D-1. Minority Household Population* of New York State In 1986 by Age -- Preliminary Estimates from the 1986 CPS

MINORITY POPULATION	Total Persons - All Ages		PERSONS AGED 60-PLUS		Aged 60+ As % of Total
All Persons	17,651,618	(100)	3,001,120	(100)	17 %
White Non-Minority	12,637,150	(72)	2,487,746	(83)	20 %
Minority	5,014,468	(28)	513,374	(17)	10 %
Black	2,337,531	(13)	281,110	(9)	12 %
Hispanic	2,107,354	(12)	158,396	(5)	8 %
Other	569,583	(3)	73,868	(2)	13 %
MINORITY POPULATION	5,014,468	(100)	513,374	(100)	10 %
Black	2,337,531	(47)	281,110	(55)	12 %
Hispanic	2,107,354	(42)	158,396	(31)	8 %
Other Minority	569,583	(11)	73,868	(14)	13 %

Note: Percentage distributions are given in parentheses and may not sum to 100% due to rounding.

* The household population excludes persons living in institutions or other group quarters.

Data Source: "1986 Current Population Survey," U.S. Bureau of the Census.

TABLE D-2. Comparison of Minority Elderly Population* Projections for 1986 to Preliminary Estimates from the 1986 CPS -- New York State

MINORITY POPULATION	Persons 60 Years Old and Over In 1986			
	1986 CPS ESTIMATE		1986 PROJECTION**	
All Aged 60+ - Total	3,001,120	(100)	2,989,000	(100)
White Non-Minority	2,487,746	(83)	2,491,000	(83)
Minority	513,374	(17)	498,000	(17)
Black	281,110	(9)	282,000	(9)
Hispanic	158,396	(5)	164,000	(5)
Other	73,868	(2)	52,000	(2)

See Table D-1 footnotes.

** Projections are those presented elsewhere in this report and are "straight line" linear projections based on average annual growth rate in CPS household population estimates for 1981 thru 1984. Separate projections for Black and Hispanic elderly were subsequently adjusted to the projection for the minority population as a whole assuming a constant "other" minority elderly population.

TABLE D-3. Minority Elderly Household Population* of New York State in 1986 by Area of Residence and Age Distribution -- Preliminary Estimates from the 1986 CPS

AREA OF RESIDENCE and AGE DISTRIBUTION	Persons 60 Years Old and Over					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
AREA OF RESIDENCE						
Number						
All Aged 60+ - Total	3,001,120	2,487,746	513,374	281,110	158,396	73,868
New York City	1,266,635	863,284	403,351	197,274	146,019	60,058
Rest of State	1,734,485	1,624,462	110,023	83,836	12,377	13,810
Central City	1,465,201	1,035,447	429,754	221,746	147,950	60,058
New York City	1,266,635	863,284	403,351	197,274	146,019	60,058
Other Central City	198,566	172,163	26,403	24,472	1,931	nr
Outside Central Cities	1,535,919	1,452,299	83,620	59,364	10,446	13,810
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
New York City	42	35	79	70	92B	b
Rest of State	58	65	21	30	8B	b
Central City	49	42	84	79	93B	b
New York City	42	35	79	70	92B	b
Other Central City	7	7	5	9	1B	b
Outside Central Cities	51	58	16	21	7B	b
AGE DISTRIBUTION						
Number						
All Aged 60+ - Total	3,001,120	2,487,746	513,374	281,110	158,396	73,868
60 To 64 Years	829,966	683,164	146,802	79,188	50,647	16,967
65 To 74 Years	1,298,722	1,064,904	233,818	122,367	71,421	40,030
75 Years and Over	872,432	739,678	132,754	79,555	36,328	16,871
Percentage						
All Aged 60+ - Total	100%	100%	100%	100%	100%	b
60 To 64 Years	28	27	29	28	32B	b
65 To 74 Years	43	43	46	44	45B	b
75 Years and Over	29	30	26	28	23B	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.
Data Source: "1986 Current Population Survey," U.S. Bureau of the Census.

APPENDIX E. Recipiency of Selected Entitlements and Benefits Reported in the 1985 CPS

The Current Population Survey collections information on recipiency under several federal programs based on the responses of persons interviewed in the survey. While internal consistency checks and appropriate allocations are performed by the Bureau of the Census, the reported CPS data may not agree with official program statistics which reflect actual transactions, beneficiaries, benefits and recipients as recorded by administering agencies.

This appendix presents the recipient data reported in the 1985 Current Population Survey for the study population, i.e., the minority elderly household population of New York State. A short description of each of the several federal programs is given below, together with a brief summary of reported recipiency data. Tables E-1, E-2 and E-3 present the reported recipiency data in detail. The program descriptions given here are as of the 1985 CPS and do not reflect any changes which may have been implemented by administering agencies.

SOCIAL SECURITY AND MEDICARE

Social Security is administered directly by the federal government. It is a general purpose program intended to provide financial security for all persons in old age and retirement, and to insure all persons against losses of income from permanent disability, death of a spouse and parent, and terminal illness. Retired workers must be 62 years of age to receive early retirement benefits, and 65 years of age to receive full Social Security benefits.

Medicare is also administered directly by the federal government. It is a general purpose health insurance program intended to ensure the provision of adequate medical care in old age, or under other conditions entitling persons to Social Security. Retired workers must be 65 years of age to be eligible for Medicare coverage.

Recipiency of Social Security benefits and Medicare coverage are not universal but restricted by eligibility requirements which must be met by older individuals who otherwise qualify due to age.

Elderly persons who are recent immigrants from abroad, who have no employment history or were employed at an occupation and job not covered by Social Security, and who can not afford required Medicare co-payments and premiums are among those who are likely to be ineligible for income or medical insurance benefits under these programs.

The younger elderly, aged 60 to 64, are ineligible for Medicare coverage unless qualifying for Social Security, not as a retired worker, but by reason of permanent disability or other insured condition. While those who are 62 years of age and are entitled may opt for reduce retired worker benefits, they remain ineligible for Medicare until they reach 65 years of age. Full retired worker benefits under Social Security are available only at age 65 and to only those who did not select the early retirement option.

The 1985 CPS reports that of the elderly population of New York State:

- 35 percent of the minority elderly (including 31 and 43 percent of the Black and Hispanic aged respectively) did NOT receive any Social Security benefits during the prior year--in comparison to 25 percent of the non-minority elderly; and,

- 33 percent of the minority elderly (including 27 and 44 percent of the Black and Hispanic aged respectively) were NOT covered by Medicare during the prior year--in comparison to 28 percent of the non-minority elderly.

SUPPLEMENTAL SECURITY INCOME (SSI) AND MEDICAID

Supplementary Security Income is administered federally in cooperation with state governments. The program provides income assistance specifically for the low income aged (65-plus), blind and disabled. SSI is an income and resource tested program with the federal government establishing eligibility requirements for federal payments nationwide, and state governments establishing requirements for additional state supplemental payments.

Medicaid is administered and funded jointly by state and federal governments. It provides health insurance coverage for low income persons, and is an income and resource tested program. Medicaid provides categorical coverage for SSI and public assistance recipients (i.e., such recipients are

automatically or "categorically" eligible), and also provides coverage for the "medically needy" whose eligibility is determined by medical expenses as well as income and resource tests. Special residency requirements apply to recent immigrants under both the SSI and Medicaid programs.

The SSI and Medicaid programs target general income and medical assistance to the low income population who otherwise qualify. Of the minority elderly household population, the 1985 CPS reported 26 percent living in poverty during the prior year, and an additional 18 percent living in marginal poverty.

The 1985 CPS further reported that during the prior year:

- o 14 percent of the minority elderly received SSI payments to supplement their income--including 15 percent of both the Black and Hispanic aged; and,
- o 26 percent of the minority elderly (including the 14 percent who received SSI) had Medicaid coverage--including 30 and 26 percent of the Black and Hispanic elderly respectively.

FOODSTAMPS AND HOME ENERGY ASSISTANCE (HEAP)

The Foodstamp program is administered jointly by state and federal governments to provide financial assistance to low income families and individuals specifically for the purchase of food. Eligibility for Foodstamps is base on income, resource tests and factors affecting need including family size.

The Home Energy Assistance Program (HEAP) is also administered jointly by state and federal governments. It provides limited financial assistance to low income families and individuals specifically for the purchase of oil, gas or other fuels used in the home for heating. HEAP is an income tested program with assistance also based on factors affecting need. Special residency requirements apply to recent immigrants under both the Foodstamp and HEAP programs.

The Foodstamp and HEAP programs are similarly to SSI and Medicaid in targeting assistance to the low income population. However, assistance is provided to households for the specify purposes of, respectively, purchasing food and paying for home heating fuels. While both of these programs are income tested, the income eligibility requirements used are broader than those under the SSI and Medicaid programs. Also the amount of assistance afforded under these programs is typically more limited with HEAP providing annual grants of one-to-three hundred dollars.

The 1985 CPS reported that during the prior year:

- o 13 percent of the minority elderly lived in households that received Foodstamp assistance--including 13 and 19 percent of the Black and Hispanic elderly respectively; and,
- o 9 percent of the minority elderly, and equal percents of the Black and Hispanic elderly, lived in households that received HEAP assistance.

PUBLIC HOUSING (FEDERAL ONLY) AND RENT SUBSIDY ASSISTANCE

Public Housing (federal only) constructed under federal programs provides housing assistance for low income families and individuals who meet income and eligibility tests for initial occupancy, and whose continued occupancy is subject to income tests set forth by the administering federal agency and local housing authority. Rental charges and increases for public housing residents are limited by federal statute and regulation.

Rent Subsidy programs for persons not living in public housing, provide housing assistance to low income families and individuals by limiting rental charges to an amount below the "fair market rent." Such programs may be administered by the federal government jointly with state governments or local governments or housing authorities, and include direct payment and interest reduction programs for owners providing lower cost housing to low income tenants.

Public housing and rent subsidies while again targeting special assistance to the low income population were reported in the 1985 CPS as being received by limited proportions of the minority or non-minority elderly.

The CPS reported a total of approximately 221,000 elderly persons lived in public or rent subsidized housing, including: 15 percent of the minority elderly; 16 and 18 percent, respectively, of the Black and Hispanic elderly; and, 6 percent of the non-minority elderly.

TABLE E-1. Minority Elderly Persons In 1985 by Coverage and Recipiency Under Selected Public Programs: New York State, 1985 CPS -- NUMBER

SELECTED PROGRAM**	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
ALL AGED 60+ - Total	2,959,697	2,485,258	474,439	270,047	152,907	51,485
Below or In Marginal Poverty - Total	790,888	586,120	204,768	122,512	71,706	10,550
- below poverty	331,206	210,000	121,206	68,755	48,894	3,557
- marginal poverty	459,682	376,120	83,562	53,757	22,812	6,993
SOCIAL SECURITY and MEDICARE COVERAGE:						
Covered by Medicare	2,114,113	1,795,961	318,152	197,970	85,799	34,383
Not Covered	845,584	689,297	156,287	72,077	67,108	17,102
With Social Security	2,169,910	1,859,435	310,475	187,580	87,171	35,724
Soc.Sec.ONLY***	433,639	321,403	112,236	72,152	32,030	8,054
No Social Security	789,787	625,823	163,964	82,467	65,736	15,761
Amt.of Social Security:						
Aggregate In $000s	$10,806,602	$9,400,584	$1,406,018	$ 836,146	$ 389,983	$179,888
Per Capita In $s	$ 3,651	$ 3,783	$ 2,964	$ 3,096	$ 2,550	$ 3,494
SSI and MEDICAID:						
Medicaid Eligible	308,388	183,519	124,869	80,420	39,895	4,554
Not Eligible	2,651,309	2,301,739	349,570	189,627	113,012	46,931
With SSI Income	161,026	94,349	66,677	40,905	23,645	2,127
No SSI Income	2,798,671	2,390,909	407,762	229,142	129,262	49,358
Amount of SSI:						
Aggregate In $000s	$ 372,883	$ 191,280	$ 181,604	$ 98,196	$ 76,593	$ 6,815
Per Capita In $s	$ 126	$ 77	$ 383	$ 364	$ 501	$ 132
FOODSTAMP RECIPIENCY:						
Received Foodstamps	143,351	79,607	63,744	35,267	28,477	nr
No Foodstamps	2,816,346	2,405,651	410,695	234,780	124,430	51,485
Value Received:						
Aggregate In $000s	$ 78,474	$ 34,948	$ 43,526	$ 27,796	$ 15,730	nr
Per Capita In $s	$ 27	$ 14	$ 92	$ 103	$ 103	nr
HOME ENERGY ASSISTANCE (HEAP) RECIPIENCY:						
Received HEAP	150,250	108,077	42,173	23,643	13,964	4,566
No HEAP Assistance	2,809,447	2,377,181	432,266	246,404	138,943	46,919
PUBLIC HOUSING and RENT SUBSIDY:						
In Public Housing	150,232	92,645	57,587	37,029	20,558	nr
Not In Public Housing	2,809,465	2,392,613	416,852	233,018	132,349	51,485
With Rent Subsidy	70,393	54,491	15,902	6,281	6,973	2,648
No Rent Subsidy	2,739,072	2,338,122	400,950	226,737	125,376	48,837
Either Public Housing or Rent Subsidy	220,625	147,136	73,489	43,310	27,531	2,648
Neither Public Housing nor Rent Subsidy	2,739,072	2,338,122	400,950	226,737	125,376	48,837

"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.
* Household population exclusive of persons living in institutions or other group quarters.
** Figures are from the CPS, and may differ from official statistics on program operations maintained by public agencies responsible for administering programs.
*** Social Security is the only source of income received.
Data Source: "1985 Current Population Survey," U.S.Bureau of the Census.

TABLE E-2. Minority Elderly Persons In 1985 by Coverage and Recipiency Under Selected Public Programs: New York State, 1985 CPS -- PERCENT OF SPECIFIED POPULATION

SELECTED PROGRAM**	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
ALL AGED 60+ - Total	100%	100%	100%	100%	100%	b
Below or In Marginal Poverty - Total	27%	24%	43%	45%	47B	b
- below poverty	11	8	26	25	32B	b
- marginal poverty	16	15	18	20	15B	b
SOCIAL SECURITY and MEDICARE COVERAGE:						
Covered by Medicare	71%	72%	67%	73%	56B	b
Not Covered	29	28	33	27	44B	b
With Social Security	73%	75%	65%	69%	57B	b
Soc.Sec.ONLY***	15	13	24	27	21B	b
No Social Security	27	25	35	31	43B	b
SSI and MEDICAID:						
Medicaid Eligible	10%	7%	26%	30%	26B	b
Not Eligible	90	93	74	70	74B	b
With SSI Income	5%	4%	14%	15%	15B	b
No SSI Income	95	96	86	85	85B	b
FOODSTAMP RECIPIENCY:						
Received Foodstamps	5%	3%	13%	13%	19B	b
No Foodstamps	95	97	87	87	81B	b
HOME ENERGY ASSISTANCE (HEAP) RECIPIENCY:						
Received HEAP	5%	4%	9%	9%	9B	b
No HEAP Assistance	95	96	91	91	91B	b
PUBLIC HOUSING and RENT SUBSIDY:						
In Public Housing	5%	4%	12%	14%	13B	b
Not In Public Housing	95	96	88	86	87B	b
With Rent Subsidy	2	2	3	2	5B	b
No Rent Subsidy	93	94	85	84	82B	b
Either Public Housing or Rent Subsidy	7%	6%	15%	16%	18B	b
Neither Public Housing nor Rent Subsidy	93	94	85	84	82B	b

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.

*, **, *** See footnotes to Table E-1.

TABLE E-3. Minority Elderly Persons In 1985 by Coverage and Recipiency Under Selected Public Programs: New York State, 1985 CPS -- PERCENT OF TOTAL PERSONS 60-PLUS

SELECTED PROGRAM**	Persons 60 Years Old and Over*					
	Total	White Non-Minority	MINORITY ELDERLY			
			TOTAL	Black	Hispanic	Other
ALL AGED 60+ - Total	100%	84	16	9	5	2
Below or In Marginal Poverty - Total	100%	74	26	15	9	1
- below poverty	100%	63	37	21	15	1
- marginal poverty	100%	82	18	12	5	2
SOCIAL SECURITY and MEDICARE COVERAGE:						
Covered by Medicare	100%	85	15	9	4	2
Not Covered	100%	82	18	9	8	2
With Social Security	100%	86	14	9	4	2
Soc.Sec.ONLY***	100%	74	26	17	7	2
No Social Security	100%	79	21	10	8	2
Amt.of Social Security:						
Aggregate In $000s	100%	87	13	8	4	2
SSI and MEDICAID:						
Medicaid Eligible	100%	60	40	26	13	1
Not Eligible	100%	87	13	7	4	2
With SSI Income	100%	59B	41B	25B	15B	1B
No SSI Income	100%	85	15	8	5	2
Amount of SSI:						
Aggregate In $000s	100%	51B	49B	26B	21B	2B
FOODSTAMP RECIPIENCY:						
Received Foodstamps	100%	56B	44B	25B	20B	---
No Foodstamps	100%	85	15	8	4	2
Value Received:						
Aggregate In $000s	100%	45B	55B	35B	20B	---
HOME ENERGY ASSISTANCE (HEAP) RECIPIENCY:						
Received HEAP	100%	72B	28B	16B	9B	3B
No HEAP Assistance	100%	85	15	9	5	2
PUBLIC HOUSING and RENT SUBSIDY:						
In Public Housing	100%	62B	38B	25B	14B	---
Not In Public Housing	100%	85	15	8	5	2
With Rent Subsidy	b	b	b	b	b	b
No Rent Subsidy	100%	85	15	8	5	2
Either Public Housing or Rent Subsidy	100%	67	33	20	12	1
Neither Public Housing nor Rent Subsidy	100%	85	15	8	5	2

Note: Percentage distributions may not sum to 100% due to rounding.
"B" = base of less than 200,000; "b" = base of less than 90,000; "nr" = no reported cases.

*, **, *** See footnotes to Table E-1.

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